S. HRG. 101-72

NOMINATION OF LOUIS W. SULLIVAN

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

FEBRUARY 23, 1989

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NOMINATION OF LOUIS W. SULLIVAN TO BE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

THURSDAY, FEBRUARY 23, 1989

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 10:20 a.m., in room SD-215, Dirksen Senate Office Building, the Hon. Lloyd Bentsen (chairman) presiding.

Also present: Senators Moynihan, Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Packwood, Dole, Danforth, Chafee, Heinz, Durenberger, Armstrong, Symms.

[The prepared statements of Senators Durenberger, Heinz, Mitchell, Dole, Moynihan and Symms appear in the appendix.]

[The press release announcing the hearing follows.]

[Press Release No. H-5, January 17, 1989]

BENTSEN ANNOUNCES HEARING TO REVIEW NOMINATION OF SULLIVAN TO BE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced today that the Finance Committee will hold a hearing to review the nomination of Louis W. Sullivan, M.D., to be Secretary of Health and Human Services.

The hearing will be held on *Wednesday, February 1, 1989 at 10:00 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

Dr. Sullivan currently serves as president of the Morehouse School of Medicine in Atlanta, Georgia.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. Good morning, Dr. Sullivan. We are pleased to have you in what I hope will be the first of many appearances before the Committee on Finance.

I note that on introducing you as his nominee for the Secretary of Health and Human Services, President Bush said that your mission would be to attempt to keep health care affordable for all Americans, to improve the quality and the efficiency of health care programs, to implement the new welfare reform laws, to help conquer the terrible tragedy of AIDS, and to carry out the campaign theme of "invest in our children."

Now, that is a formidable agenda for any administration, let alone one agency within an administration.

I must say that I found refreshing the President's words regarding access to affordable health care, implementation of a welfare

bill designed to emphasize education and training, and his expressed intent to devote serious attention to investing in the future of our Nation's children.

As you know from our earlier conversation, my hope is that this committee will spend considerable time over the next two years on each of these issues. In particular, I am deeply concerned about the financial condition of rural hospitals and have introduced legislation, with the support of most of the members of this committee, to try to address that particular problem.

Since the adoption of the Prospective Payment System for Medicare, more than 150 hospitals have closed their doors. That reduces the access to care for thousands of elderly persons, particularly those living in small towns across America. Recent reports say that 600 hospitals may be in trouble if something isn't done to address that problem.

But I am also very interested in hearing about your plans for a more meaningful Federal investment in the future of our young Americans. We have had some dramatic changes in the family structure over the last few years. Currently one in five children now lives in poverty. More than half of all American youngsters will spend at least a portion of their young lives living with a single parent. Only half of those with incomes below the Federal poverty standard have access to health care, and all too many children leave school without the skills that are needed to compete successfully in this competitive world of ours.

It is a national tragedy that we have failed to continue the progress of the Sixties and the Seventies in driving down the rate of infant deaths in this country, particularly when the investment in low-cost prenatal care pays dividends of about $3 for every dollar that we invest.

Yet these issues and many others on which I hope we can work together, will have to be addressed in the face of severely constrained resources.

With a deficit of some $135 billion—and that is what is projected for Fiscal Year 1990—we are going to have to be pretty creative to meet some of these objectives.

The members of this committee are acutely aware that the last budget submitted by President Reagan called for a $6.5 billion cut in health programs under the jurisdiction of this committee and limited funding for the education portion of the Welfare Reform Bill to less than half of what had been agreed to when the bill was signed into law last year. President Bush appears to agree that $5.5 billion in Medicare cuts will be needed this year.

So, as you address this committee this morning, I hope you are going to spend some time outlining in some detail the priorities, both budgetary and programmatic, that you expect to set for the Department of Health and Human Services during the coming year.

I would now defer to some of your very distinguished friends who are here to introduce you this morning. We will start with Senator Fowler.

STATEMENT OF HON. WYCHE FOWLER, JR., A U.S. SENATOR FROM GEORGIA

Senator FOWLER. Mr. Chairman and members of the committee, it is my distinct pleasure, along with my colleagues from Georgia and other members of the Congressional delegation who join me at the table to not only introduce Dr. Louis Sullivan to you but to commend him with full hearts and with strong minds to you, to this committee, and to the United States Senate, as our next Secretary of Health and Human Services.

I have known Dr. Sullivan for many, many years. I am going to let others speak of his personal qualifications, which I think you will find not only impressive but compelling in and of themselves, but I am going to be very brief because of the number of people who would like to say a word and just speak a little personally about him.

As you know, Dr. Sullivan is the inspiration and architect of the only Black medical school that has been built in this century. Without his leadership, inspiration, and drive, that would not have come about. There is no question in my mind about it. It was a dream. No one thought it could be done. He enlisted the aid of some of us, including the now President of the United States, and through almost 12 years of constant, incessant activity, because he believed, he brought about the Morehouse Medical School which is a model of its kind in the country.

Mr. Chairman, by the way, may I take this opportunity to introduce his family to the committee?

The CHAIRMAN. By all means, Senator.

Senator FOWLER. Mrs. Sullivan, will you stand?

His wife Ginger; his son Paul, who is a practicing physician in Atlanta now with the Public Health Service, in his public capacity of public service; his son Halsted, who is the President of the Student Body at the University of Virginia in Charlottesville; and his daughter Shanta, who is now a beautiful professional woman but started out as an interne in my office seven years ago—[Laughter.]

So I am extremely proud of her.

Mr. Chairman, in Shaw's "Pygmalian," that wonderful play that has been made into "My Fair Lady" thousands and thousands of times, there is a great scene where the old professor Dr. Henry Higgins is trying to teach something, even some basic manners, to the little flower girl Eliza Doolittle.

In coming over here this morning I was thinking about that scene and thinking of Dr. Sullivan. He is there at the dinner table, frustrated. He is just trying to show her which fork to use and which knife to use and how to be presented to proper society. And then in a moment of great frustration, he throws down his books, and he looks across the table, and he says, "Actually, the great secret in life, dear Eliza, is not whether you have good manners or bad manners but the same manner towards all people, to act as if you are already in heaven where there are no second class citizens and one soul is as good as another."

I can assure you that, whether dealing with rural hospitals or the health of the poor or the suffering of AIDS patients, all of the charges that we will give him in his public capacity as Secretary,

Dr. Sullivan will exemplify the same manner towards all people. And in that will be a model of public citizenship and public service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I would like to note that Senator Nunn of Georgia wanted very much to be here to join in the introductions but has other responsibilities this morning and can't be here, I am advised.

I would like to call on the Honorable John Lewis, United States Representative, State of Georgia.

STATEMENT OF HON. JOHN LEWIS, A U.S. REPRESENTATIVE FROM GEORGIA

Congressman LEWIS. Thank you very much.

Mr. Chairman and members of the committee, my colleagues and friends from Georgia, I am happy to appear before you today to present to the Committee Dr. Louis Sullivan of Atlanta, Georgia.

I appear before this distinguished panel, Mr. Chairman, to urge you to confirm President Bush's nomination of Dr. Louis Sullivan as Secretary of the United States Department of Health and Human Services.

Dr. Sullivan is a resident of the Fifth Congressional District of Georgia, the district that I represent. I have known and have had the pleasure of working with Dr. Sullivan on numerous health care initiatives for more than 12 years. He has led Morehouse Medical School in its mission to serve the underserved, and for that, all of us are very grateful. His work at the Morehouse School of Medicine has helped improve the quality of life in the City of Atlanta as well as the State of Georgia, the South, and throughout this Nation.

During his medical career, Dr. Sullivan has distinguished himself as someone who makes things happen. He is a creative visionary who turned dreams into reality. As a founder of the Morehouse School of Medicine, the founding President of the Association of Minority Health Professional Schools, and the founding dean and director of the Medical Education Program at Morehouse College, he has made a significant contribution to the community by providing quality health care to urban and rural poor in the South.

Now, Dr. Sullivan's resume is too long for me to review at this point. However, Mr. Chairman, his resume reflects and I can testify to the fact that Dr. Sullivan is an able manager and a good administrator, who is experienced at making tough and hard administrative decisions.

Mr. Chairman, I would like to conclude by saying that I am very proud and pleased that President Bush had the confidence and foresight to nominate this American medical pioneer to head the United States Department of Health and Human Services, and I urge the members of this committee to approve Dr. Sullivan's nomination.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Congressman Lewis.

We have the Honorable Newt Gingrich, if you would make your statement, please.

STATEMENT OF HON. NEWT GINGRICH, A U.S. REPRESENTATIVE FROM GEORGIA

Congressman GINGRICH. Thank you, Mr. Chairman.

I first met Dr. Sullivan when he was in a very small office with two people, beginning to build Morehouse Medical School. I was struck by the fact that he had a commitment not just to have a traditional medical school but to have a commitment serving the poor, to having a commitment to preventive health care, and to being a pioneer in how we deliver the services and the attitude with which we deliver the services so vital in health care.

I watched him work, and he is both an exemplary model of President Bush's description of "a thousand points of light," because it was a private medical school, and an awareness that there are times when it is useful to have Government batteries to provide help to those points of light, because he was willing to work on a bipartisan basis, to work with the Federal Government, to seek funding wherever possible.

And I watched over the years, as he came to this city, reaching out to Democrat and Republican alike, and in that process I think proving to Barbara Bush and George Bush and many other people that he had a commitment to serving human beings that is quite remarkable.

I want to commend him to this committee as a man I have watched closely as a fellow Georgian, the man I have worked with on a variety of projects, because I am convinced that in a broad way he blends the best of George Bush's philosophy with an absolute commitment to humanitarian solutions that will work, that are practical, and that are do-able.

I think this committee will find over the next few years that, as we tackle the very complicated problems of welfare and the very complicated problems of health care, you will have confirmed the kind of skilled, compassionate, and caring professional that you will be proud to see plunge into the thicket and try to produce practical, common-sense solutions that you can approve of, that you can finance, and that you can look back on saying, "Just as he was successful at Morehouse, it was good to work with Lou Sullivan and help build a better system for America."

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Congressman Gingrich.

Dr. Rowland, we are pleased to have you.

STATEMENT OF HON. J. ROY ROWLAND, A U.S. REPRESENTATIVE FROM GEORGIA

Congressman ROWLAND. Thank you very much, Mr. Chairman, and may I thank you and the members of this committee for the opportunity to speak this morning in support of Dr. Sullivan's confirmation as Secretary of the Department of Health and Human Services.

Anyone who looks over Dr. Sullivan's resume will quickly realize that he is one of the country's most accomplished leaders in health care. He has been a practicing physician, a medical teacher both at Harvard and Boston University, a medical researcher. He is a noted writer who has published several articles, a truly remarkable

administrator who built the Morehouse Medical School, and a consultant and advisor to many health care organizations throughout the country. He is a civic leader. He is the recipient of more honors and awards than he probably remembers.

But I want to focus my remarks very briefly this morning not on his record but what I have observed during the 12 years that I have known him as a person and as a fellow physician.

I first met Dr. Sullivan when I was a member of the Georgia House of Representatives, and at that time he was seeking support for funding at the Morehouse Medical School, which had the special mission of helping to overcome the shortage of minority physicians that we had not only in Georgia but throughout other areas of our country.

In his own quiet way, he sold me on the real need for Morehouse Medical School and what it would contribute to our own State of Georgia. He really must have convinced many other members of the Georgia House and Georgia Senate, because very shortly he had the overwhelming support of all of these people.

He proved back then that he knows how the political process works. He has never needed to be confrontational. He has always preferred to work and reason with those with whom he disagreed or disagreed with him, and he has always been effective in building bridges and coalitions that have helped him gain his goals.

You know, it wasn't easy to build the Morehouse Medical School into the institution that it is today, and there were many people who said it would never succeed financially. Well, looking back on it, I know now that it couldn't have failed. Because of his administrative ability, his dedication, and his integrity, his political knowledge and skill, his capacity for inspiring others—all of these qualities contributed to the great success of that school.

So, Mr. Chairman, needless to say, I believe that Dr. Sullivan will be one of our country's greatest Secretaries of Health and Human Services, and I speak not only for myself but for all members of the Georgia congressional delegation.

Thank you again for the opportunity to be here this morning.

The CHAIRMAN. Thank you, Dr. Rowland.

I see Congressman Ben Jones of Georgia is here. Would you care to make a comment?

STATEMENT OF HON. BEN JONES, A U.S. REPRESENTATIVE FROM GEORGIA

Congressman JONES. Mr. Chairman, I just wanted to add a few comments on behalf of my constituents. So many of them have called me and spoken to me in words of the greatest and highest praise for Dr. Sullivan. As Dr. Rowland very aptly put it, all Georgians are very proud of the Morehouse Medical School, and more proud of Dr. Sullivan, his work, and his character. He is an asset to Atlanta, an asset to the State of Georgia, and he will be a great asset to our Nation.

I thank you.

The CHAIRMAN. Thank you very much, Congressman.

I would like to turn to Senator Packwood for a comment.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. I just wanted to say one thing in response to Wyche's comment.

I recall, in "My Fair Lady," after they have the exchange about the manners, she says, "But that is no justification for how badly you treat me." [Laughter.]

To which he responds, as I recall, "That proves my point, my dear. The question is not do I treat you badly, do I treat anybody else any differently?"

I would hope that Dr. Sullivan will treat us nicer than Henry Higgins treated everybody. [Laughter.]

Senator FOWLER. I yield to your scholarship. The gentleman from Oregon is correct, but that is only the secular interpretation. [Laughter.]

The CHAIRMAN. Thank you, gentlemen. We appreciate very much your attendance, your comments and your statements, and I would now turn to Senator Packwood for any comment he might make.

Senator PACKWOOD. I have no opening statement. I will have a fair number of questions of Dr. Sullivan, but I would like to get on with his statement.

The CHAIRMAN. Are there members of the committee that want to make an opening statement? You will have an opportunity to question the witness, but are there any statements that you would like to make at this point?

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. I just have a very brief statement, Mr. Chairman.

First of all, I want to thank Dr. Sullivan for taking the trouble to come visit with each of us. I was especially impressed with Dr. Sullivan's emphasis on two things: one, health care access that is, the availability of health care to low income individuals; and, two, preventive medicine, that is, trying to keep people well. Those are the two areas that I am deeply concerned about, and I was especially pleased that those were areas that Dr. Sullivan was likewise concerned about.

Finally, I would just like to say one thing, if I might, Dr. Sullivan. I think all too often those that we confirm go off into their jobs and look on this committee as an experience they are glad to have been through but don't wish to repeat. I would hope that you would instead look on this committee, individually and collectively, as a group who are here to help you. It is not a confrontational organization; we are allies of yours. We want to see you succeed.

Thus, if you have problems where you think we might be helpful, either individually or as a committee, I hope you would come back to us and outline those problems, and see if we can help. We may not be able to, but we are certainly here to try to make you, as was previously said, the best Secretary of Health and Human Services there has ever been.

Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes.

Senator Bradley?

OPENING STATEMENT OF HON. BILL BRADLEY, A U.S. SENATOR FROM NEW JERSEY

Senator BRADLEY. Mr. Chairman, I would be very brief. I would just say, with a President who wants a "kinder, gentler nation," a Chairman who has put the health care of our children foremost in his agenda, and a Secretary like Dr. Sullivan, I have high hopes for this Congress.

The CHAIRMAN. Thank you.

Any further comment?

Senator SYMMS. Mr. Chairman, I would just like to ask to submit my opening statement and a series of questions for the record for Dr. Sullivan.

The CHAIRMAN. Let me state that that will be done for all members of the committee.

Dr. Sullivan, we are very pleased to have you here. I would like to state, for the record, that this committee has been ready to have you appear before it for quite some time, and you have been ready to appear, too. But as we have seen, it takes some time to get the paperwork done these days for confirmation purposes. We are pleased that that has been accomplished.

Dr. Sullivan, if you would, proceed.

STATEMENT OF LOUIS W. SULLIVAN, M.D. SECRETARY-DESIGNATE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; WASHINGTON, DC

Dr. SULLIVAN. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am honored to appear before you today. I am honored, first, because of the confidence of our new President, who has entrusted to me the nomination to be Secretary of the Department of Health and Human Services, the leadership for this important government agency.

I admire George Bush. I am, frankly, proud to be one of his friends. If I am confirmed, I shall carry out the task which he has given to me in such a way that the hopes and the aspirations which we mutually hold for this Department and for the American people are fulfilled.

I am privileged to have the opportunity to discuss with this distinguished committee the broad contours of those hopes and aspirations. They center on the President's commitment, a commitment which I fully share, to the ideal of a kinder, gentler America.

No Department will be more directly affected by that commitment than the Department of Health and Human Services, which touches the lives of all Americans when they are most vulnerable—from birth to death, through health and sickness, from the foods we eat to the medicines we take, to the care of our elderly and the disabled.

Taking that commitment as my guide, I intend to see to it that the regulations we promulgate at Health and Human Services carry a firm, but gentle touch. I intend to see that HHS employees

take pride once more in the invaluable services they offer and render to all of our citizens; that our government itself comes to have a more human face.

This may seem an unreasonably idealistic goal; but in our lifetime, many idealistic goals have in fact become reality. We have put men on the moon and brought them back to earth safely; our economic system has brought wellbeing to untold numbers in our society; and our once segregated society in which I grew up, where the color of one's skin determined where one lived, ate, and other parameters, is evolving into a nation of good will and mutual understanding.

This has been especially so in my native South, where I was born and grew up, and where remarkable progress has occurred over the past two to three decades. This region of the country is now providing leadership to the rest of our Nation in tolerance and good will.

A tolerant, compassionate society is no longer merely an idealistic goal; it is really within our reach. I have seen these momentous changes in my own life.

When I entered medical school in 1954, the year the Supreme Court struck down segregation in public schools, there were less than 5,000 Black doctors in all of the country, less than 3 percent of the nation's physicians. It then seemed naive to suppose that the medical profession could ever be completely open to all.

But today, as you have heard, my oldest son is a doctor, and the Morehouse School of Medicine, a predominately Black institution, is a reality which is already sending scores of young, minority women and men to medically-underserved rural areas and inner cities in our country.

Bringing a new spirit of compassion and kindness to a vast federal department, with more than 114,000 employees and a budget greater than $400 billion, may seem excessively idealistic, but it is an ideal which we can attain. Nothing less shall be my goal as Secretary of the Department of Health and Human Services.

As a physician and as one who has come from a proud family with modest means, I have a special appreciation for the responsibilities of this department. During my medical career over the past 30 years, I have seen remarkable progress in our Nation's system of health care, with the enactment of programs like Medicare and Medicaid making available to the elderly and the poor, services available prior to that time only to the rich. And as an academician, I have rejoiced in the great strides we have made against cancer, against polio and other dread diseases, through research supported by the National Institutes of Health.

When I was a medical student in 1956, I spent much of my third year putting patients who were afflicted with the paralytic polio into and out of iron lungs. Now, because of medical research and the advances made resulting from the research of John Enders, who received the Nobel Prize for his work, we no longer have polio as a major public health threat, because of the improvements and the development of the polio vaccine from the research coming out of his laboratory at Harvard Medical School.

Much remains to be done, however, and it must be done with an eye to reducing the Federal budget deficit—a concern I know you

share on this committee, as you consider not only how funds are spent but also how they are raised.

Let me indicate how we might begin to make further progress towards improving the health and well-being of our citizens, bearing these financial constraints in mind.

First, we must assure the continued solvency of programs like Social Security and Medicare. We must find ways to constrain our escalating medical costs, without sacrificing quality health care and access to health care. We must emphasize health promotion and health maintenance strategies, because promoting health is ultimately more humane and more economical than merely treating medical disorders once they have occurred.

Second, we must sustain and improve programs like Aid to Families with Dependent Children and Head Start, programs which help the poor to learn and help them to work their way out of poverty. Implementation of last year's welfare reform legislation will therefore be one of my highest and earliest priorities.

Third, we must seek ways to strengthen family life and reinforce our society's sense of community, our sense of commitment to one another, and our mutual responsibility to our fellow man.

As President Bush noted, "family...is a powerful word, full of emotional resonance," and those of us who have been blessed with strong families have a responsibility to aid those who have not.

Attention to family means attention to the health and the welfare of our children. This must be of primary concern, for nothing less than our Nation's future is at stake. Today that future is threatened by an unprecedented incidence of drug abuse in our society among our young people. I am deeply committed to the battle against this scourge and will work long and hard with this committee and with the President and his drug advisor in pursuit of victory against this scourge.

Fourth, we must maintain and enhance our commitment and our support for our biomedical research efforts in our quest for a cure against AIDS. As the President has said, "We must commit the resources and the will to find a cure. The American scientific community must know that we have the resolve to beat this disease." At the same time, however, we must not slight our efforts to conquer cancer, heart disease, diabetes, arthritis, and the many other disorders afflicting our citizens.

Finally, with limited resources, we must focus them primarily on the poor, on the disadvantaged and the neglected in our society. Programs like Medicare and Medicaid must be carefully administered so that rural and inner-city health needs are met and the Nation's poor are accorded decent care, given with dignity.

During my career as a doctor and as a scientist and teacher and administrator, I have developed the habit of consultation—of seeking the wisdom and experience of others, exploring many alternatives, sometimes playing the devil's advocate in order to understand all sides of an issue. As my wife and three children who are with us today will attest, this is very much a part of my nature.

Such free and robust discussion was an essential part of my leadership ability and responsibilities as President of the Morehouse School of Medicine. As nominee for Secretary of Health and Human Services, however, it has made for a good deal of press.

Thus, with apologies to Senator Packwood for having misspoken when we met, and having caused confusion, please allow me to clarify my views.

I am opposed to abortion, except in the case when the life of the mother is threatened, or in cases of rape or incest.

I support a human life amendment, embracing the exceptions just noted.

Like President Bush, I would welcome a Supreme Court decision overturning *Roe* v. *Wade.*

If confirmed by the Senate, I will actively encourage adoption and other alternatives to abortion.

I hope this clarifies my position on this very difficult issue of abortion.

When the President nominated me for this position, he presented to me a major challenge. If confirmed by the Senate, I will need and I will seek your advice and your counsel in meeting that challenge. I intend to approach it in the spirit of a charge I gave to the first graduating class of the Morehouse School of Medicine in 1985. I challenged those young graduates as follows:

"Continue to grow—in knowledge, wisdom, excellence, and service—for the rest of your lives in your quest to be the complete physician. That physician is a scientist, an educator, a humanitarian, a counselor, a leader, and a friend to his patients and to his community. He is never satisfied with his level of professional attainment but is forever seeking the higher ground, to master the new biology, to comprehend more fully our ever-expanding technology, to increase his understanding of the social, the philosophical, and the ethical dilemmas which confront us now and will confront our society for many years to come. This is an awesome and welcome challenge."

The challenge I issued those young doctors is also mine. With the support of my wife Ginger and my three children, Paul, Shanta, and Halsted, with the continued confidence of our President, and with your concurrence, I intend to meet that challenge, in service to the people of the United States.

Thank you very much, Mr. Chairman, for this opportunity.

[The prepared statement of Dr. Sullivan appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Sullivan.

Dr. Sullivan, you know, part of the delay in these hearings was brought about by the time that was necessary to work out some of the details of your leave of absence from the Morehouse School of Medicine while you are Secretary of HHS.

Now, so that there are no ambiguities concerning that, would you state for this committee the arrangements of your leave of absence?

Dr. SULLIVAN. Yes, Mr. Chairman, and thank you for the opportunity to respond to that question.

I have requested and have been granted by the trustees of the Morehouse School of Medicine an unpaid leave of absence as Professor of Medicine. Upon my confirmation by the Senate, my resignation as President of the institution will be submitted to the trustees.

Being Professor of Medicine on leave of absence will allow me, at my own expense, with no contribution from the Morehouse School of Medicine, to continue to participate in the fringe benefit programs offered to the faculty of that institution—such things as life, health and disability insurance.

Although I had an employment contract dating to July 1 of 1985 which allowed me, when I severed from the institution, to receive payments based upon a formula of 13.5 years of service to the institution of some $300,000, none of that will be taken. And because of questions which arose about that, in my effort to make sure that there would be no questions concerning my service as Secretary, and no questions concerning the high ethical standards of our President and the members of his Administration, and, finally, so there would be no question concerning the appropriate actions taken by the institution which has been so much a part of my life, I felt it was more important to clear up those questions by the actions I took; although, it had been determined that I was fully entitled to those benefits.

The CHAIRMAN. Doctor, let me get to the pension benefits. How would you handle that during the transition? Who will be making the contributions to the pension and benefit program?

Dr. SULLIVAN. I will, sir, from my personal funds.

The CHAIRMAN. Does that mean 100 percent?

Dr. SULLIVAN. One hundred percent.

The CHAIRMAN. Let me state for the record that in a number of other instances where these kinds of exemptions have been made, that usually the institution continues to pay part of the contributions for the benefit programs and the pension programs, and Dr. Sullivan here is talking about paying 100 percent of it.

I would also like for you, Doctor, to give me some examples for this committee as to instances where they have allowed leaves of absence from institutions where that person was employed when they left to take a public position. Do you have some of those examples you would like to cite for this committee?

Dr. SULLIVAN. Oh, yes. There have been a number of those instances. I believe that attorney Archibald Cox took a leave of absence from Harvard when he served in the Federal Government, Dr. Schlesinger, Attorney General Edward Levy and a number of other individuals. Those are the ones that come to mind immediately. But there have been many others.

The CHAIRMAN. Well, for the record, Governor Sununu, Secretary Shultz, Michael Boscomb, FDA Commissioner Frank Young, HCFA administrator Bill Roper, and as you state, quite a number of others.

Now, there have been some reports in the paper, and I would like to see if we can't put those to rest also. The press reported about a relationship that existed between the Commissioner of Fulton County, Commissioner Eaves, and the Morehouse School of Medicine, where he was paid a salary by Morehouse for unspecified services. In order that we might complete a full record here and lay to rest some of those concerns that some of my colleagues in the Senate might have from reading the newspaper accounts, would you explain the circumstances of the Eaves contract to this committee?

Dr. SULLIVAN. Yes, Mr. Chairman, I would be very pleased to do so.

I would point out that Mr. Eaves was an attorney who had served on the faculty of a medical school in Boston prior to coming to Atlanta and had a long-standing interest in health. But he indeed was employed by the Morehouse School of Medicine as a part-time lecturer for a period beginning in 1984. He was a member of the Fulton County Board of Commissioners, and it was our understanding that any conflict of interest provisions were approved and had been reviewed by the appropriate bodies there.

It turned out that was not the case. This was a serious error on our part, in not assuring that that had been done. When this came to our attention, we took a number of actions which were presented to our board of trustees.

First of all, we developed internally at our institution our own conflict-of-interest policy which had not been previously developed. Secondly, we had an audit done of all outside contracts by our auditors Peat, Marwick and Maine, and they determined there was no other instance like that during the history of the medical school.

We made a public statement in Atlanta indicating that we had made an error in not monitoring this situation carefully and closely, and we have taken steps that I believe will assure that this will not happen again.

The CHAIRMAN. For the benefit of the committee, I have looked at the FBI report, and I don't see from that report anything that would disqualify Dr. Sullivan for this position.

Now, Dr. Sullivan, there is considerable opposition to cutting the Medicare payments by more than $5 billion as presented in the Bush Budget, and that proposal comes on top of what we already did in the Summit Meeting in December of 1987, where we have over the last two years cut back on Medicare payments, and now we are seeing the closing of hospitals across the country, closures often correlated with these reductions in Medicare payments.

Now, I further note that 60 percent of the Medicare savings as set forth in the Bush Budget would be obtained by reducing hospital payments. Can you suggest any alternative strategies for more equitable reductions in that regard?

Dr. SULLIVAN. Well, Mr. Chairman, let me point out first of all that, as I mentioned in my opening statement, we are all very much concerned about escalating medical costs. Certainly as a physician and as a medical school administrator I have been concerned about this problem for many years. We have seen that our Nation spends a high percentage of its gross national product on health care, although our health indices in this country are not the best in the world.

What the President's budget proposes actually, I believe, is close to an $8.5–$9 billion increase in the funding for Medicare over the level for this year, and the $5 billion reduction would be a reduction from the projected full level of increase in that budget.

Further, that reduction is aimed primarily at the providers and not a cut in benefits for the recipients of Medicare.

I think we are going to have to work very hard to try and make sure that we do come up with equitable solutions for restraining health care costs while maintaining access, and so we are very con-

cerned that we do everything possible to see that beneficiaries in rural and inner-city areas continue to receive the benefits which they are due; but we obviously have to try to do this in a way that we do not exceed reasonable costs.

The CHAIRMAN. Well, Dr. Sullivan, I think we need something more definitive than that; but I will get into that in the second round of questioning.

We will hold the questioning to five minutes. The order of arrival, insofar as the members of the committee: Mr. Baucus, Mr. Heinz, Mr. Chafee, Mr. Packwood, Mr. Rockefeller, Mr. Danforth, Mr. Bradley, Mr. Dole, Mr. Moynihan, Mr. Durenberger, Mr. Symms. We will follow that, and please limit your questioning to five minutes.

Senator ARMSTRONG. Mr. Chairman, would the Chair note that Senator Armstrong is here, and I would like to be on the list before there are any more arrivals. [Laughter.]

The CHAIRMAN. Well now, let me state—let us see, did I name Mr. Mitchell? He is on that list, and I will put you immediately behind his name. Senator Armstrong, it is so noted.

And with that, Senator Baucus?

Senator PRYOR. By the way, Mr. Chairman, did you mention Senator Pryor? I am barely here, the record can state that. [Laughter.]

The CHAIRMAN. And Senator Pryor.

Senator PRYOR. Thank you. [Laughter.]

The CHAIRMAN. And will Staff be more careful and give me an updated list next time? [Laughter.]

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

Doctor, as you know, when the Government moved from cost-based reimbursement of hospitals through the Medicare system to prospective payment, it was based on the assumption that the most efficient hospitals would survive and the most inefficient would fail. And it was further based somewhat on the assumption that our country is homogeneous—that is, we have a homogeneous population, density—so that if an inefficient hospital failed, patients could go to a nearby more-efficient surviving hospital.

I know you pride yourself, as a physician and as an educator, on being very sensitive to underprivileged and rural needs, particularly in your own State of Georgia, and I commend you for that. I would like to further sensitize you to the plight of rural America by pointing out the difference between the rural South and the rural West. In your own State of Georgia, let's take the hospital in Rockmart, for example. It is in Pope County, Georgia, a hospital with about 44 beds. If Rockmart Hospital fails, patients can go just 15 miles away to Dallas, Georgia, where there is a 200-bed hospital. It is a rural hospital, Rockmart, but there is a hospital of 200 beds only 15 miles away.

Contrast that with some hospitals in the West. Let's take the hospital in Glendive, Montana, for example. That is another small

rural hospital, 46 beds—about the same size as Rockmart—but if the Glendive hospital fails, then those patients have a problem, because the nearest 200-bed hospital is in Billings, Montana, which is a 225 mile drive. And that is like driving from Atlanta to Knoxville. That is a bit of a drive for some folks. It is also the same distance as from Washington, D.C. to Newark, New Jersey, and that is a bit of a drive for some folks.

In addition to that, sometimes the weather in the West isn't all that great. When it was 55 degrees above zero in Georgia, it was 55 degrees below zero in Montana. So, if a woman who is pregnant suddenly gets labor pains and has to go to the hospital to deliver, her car might not start very easily if it is 55 degrees below zero.

So I am asking you, what are you going to do to help that lady? [Laughter.]

What are you going to do to be sure that she is taken care of, and other people like her, to be sure that rural health care survives? Those folks need access to health care and, if rural hospitals do not survive, then they have no health care.

Dr. SULLIVAN. Well, Senator Baucus, you certainly address an issue that I am very concerned about, because my medical school is designed to train young people for service both in inner-city and rural areas, and as part of that we are affiliated with rural hospitals as well. One such hospital did close in Tuskegee, Al., the John Andrew Hospital, which had a distinguished history over a number of years.

So we are acutely aware of the problem, because that was the only hospital in Makin County, Alabama, serving a predominately Black area where the incidence of infant mortality is comparable to that of some countries in Central America, so we are certainly acutely aware of the need for doing everything we can to preserve rural health services or making them continue to be available.

As you know, the Department has been trying to address this and is working, for example, to try and eliminate or minimize, at least, the differential reimbursement rates that exist presently between urban and rural hospitals. This is an issue that we will continue to look at.

We are also looking at such programs such as the National Health Service Corps that works to place health professionals in medically-underserved areas.

This is obviously a very complex question and one which as you know, has a number of diverse factors that really make each situation somewhat individual; but I can assure you that I do have and have had for many years a very real concern for doing everything possible to see that people in rural communities, as well as the inner city, have those facilities.

So I will really look forward to looking at that and working with you and other members of the committee to do everything we can.

Senator BAUCUS. I appreciate that. The hospital I mentioned at Glendive, MT is not an isolated example; it is a representative example. Part of America, particularly in the West where there aren't as many people per square mile, is a part of the country that depends on rural hospitals, and we have to address the problems they face.

I am also happy to hear you say that you are going to address, in fact eliminate, as I understood you, the urban-rural payment differential. Did I understand you correctly?

Dr. SULLIVAN. Well, working to minimize that is obviously going to take a lot of time and effort, but we are working on it, yes.

Senator BAUCUS. Well, that is a provision in the bill introduced by the Chairman. Senator Dole is also a cosponsor, and I am a cosponsor of that same bill.

In addition, I ask you to look very closely at moving back to cost-based reimbursement for rural hospitals with 50 or fewer beds, to keep a hospital from failing. The differential elimination is not nearly sufficient protection for the smaller rural hospitals, the ones that are most isolated. That is another factor you have to look at.

I also ask you to look at the differential that physicians in rural areas get paid compared with urban physicians. It is pretty hard for a doctor who is the only doctor in town, on 24-hour call, when he sees that his urban counterpart is getting paid 30 percent more under Medicare than he is. If we are going to keep physicians in rural America and therefore keep rural hospitals open, we are going to have to find a way to address Medicare reimbursement to rural physicians.

That is not only addressing the differential between the highly-reimbursed procedures, like cataract surgery, and paying more to primary care physicians; it is also, in addition, paying more to rural physicians so that they get paid more nearly as much as urban doctors.

Thank you.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Sullivan, in your outline of your arrangements with Morehouse Medical School, are you foregoing $300,000 of pension or something? I didn't quite understand that.

Dr. SULLIVAN. Yes, Senator Chafee. It was a severance payment that I have foregone. This was because of the fact that, as the issue was presented in the press, I was concerned that (a) the President and members of his administration not be questioned in terms of the propriety or the ethical standards under which we would be operating as public servants.

I was also concerned about the image of the Morehouse School of Medicine, which has been an institution that has tried to develop, and indeed, depends very much upon having the public trust.

Third, I was concerned about my own capabilities of providing leadership to this vast Department and the number of problems that we face if there were any residual cloud there.

Therefore, because of my concern about all three of those factors, I indeed asked the trustees of the college, and they agreed to forego that arrangement and simply give me a leave of absence as Professor of Medicine without pay.

Senator CHAFEE. Well, it just sounds like an extremely strange arrangement. We don't expect people to come into Government as paupers and go out as rich people, but we certainly don't expect people to come into Government moderately well off and leave as paupers, either.

I don't know what arrangement there has to be to cause somebody to give up $300,000 to serve in a job that will require 24 hours of your day and all kinds of grief. I think we ought to take a look at the ethics laws we are promulgating around this place.

Dr. SULLIVAN. Senator, may I please comment?

Senator CHAFEE. Yes.

Dr. SULLIVAN. Certainly, I think a review I would welcome. [Laughter.]

Senator CHAFEE. But the horse is out of the barn, as we say, isn't it? [Laughter.]

Dr. SULLIVAN. Yes. But I would say this: I look upon this as a real opportunity for public service, to work with President Bush and with you and your colleagues here in the Congress, to really try to help improve the services available to our citizens, coming at a difficult time in our Nation, in which we have limited resources. So, I feel this is very important.

Senator CHAFEE. Well, I know it is a tremendous privilege to work with us. [Laughter.]

But I don't think you ought to go through a toll booth where the charge is $300,000. [Laughter.]

Well, I am sorry about that—probably not half as sorry as you are. [Laughter.]

Well, what I would like to ask you specifically, Dr. Sullivan is about a matter that is close to my heart. It is a bill called "The Medicaid Home and Community Quality Services Act." It has 43 cosponsors, and our distinguished Chairman has said that we can have a markup early this year. I am interested in your reaction to it.

Basically, what it does is to remove the necessity of obtaining a waiver in order to provide home care under the Medicaid program. That is essentially what it does. In other words, Medicaid assistance would not be available solely to those who are institutionalized, but it would also be available in a different setting—it might be in the person's own home; it might be a foster home; or it might be a community setting of some other type, such as a small group home.

In the past, the Administration has been at best lukewarm on this. I would be interested in your thoughts. It is a great opportunity to strike a blow for a splendid piece of legislation. [Laughter.]

Dr. SULLIVAN. Thank you, Senator Chafee.

Let me say this: I certainly am very supportive of doing everything we can to promote home care, for a number of reasons—first of all, to maintain people in their homes as long as possible, I think for most people that is preferable to institutional care. Secondly, because institutional care is so expensive, and we are working to try to contain health care costs, we would welcome any strategy that is effective that will also help us address restraining health care costs.

Now, the specifics on the bill that you have introduced, I would have to say that I am not familiar with those, and therefore I couldn't really speak beyond that. But I certainly will assure you that I will become familiar with this and will certainly be very pleased to review this with you and to discuss this issue with you,

in order to do everything we can to improve the availability of home health care.

Senator CHAFEE. I would just like to ask one other question—and my time is short here. One of the big problems that we have in our country, as you know, is that 37 million Americans have no health care insurance, and a large proportion of them are children. One of the efforts we are trying to do is to provide for a Medicaid buy-in for what you might call the working poor, and to sever the tie between welfare and Medicaid which has previously existed.

I would encourage your support in those efforts, likewise. Again, it is an extension of Medicaid. Have you given any thought to that?

Dr. SULLIVAN. Yes. As you know, I am pleased that President Bush has himself proposed a buy-in for Medicaid to expand the availability of Medicaid to our low-income citizens. And certainly, I see this as part of a larger problem of the 37 million uninsured individuals.

I think the Medicaid buy-in is part of the solution, but I see the need for a lot more activities to address the medically-uninsured. We certainly need to encourage the private sector to make available such insurance for those individuals, as well as to work with industry, for them to expand the availability of health insurance for their workers.

So I really see this as an effort with Federal participation, participation of the States, local government, and the private sector, as well.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. Doctor, you are an educator. The last two months must have been quite an education for you. [Laughter.]

When you came to my office, we talked about abortion. I thought you had, initially, the perspectives about right as to the obligations of your Department. You came in to me and you said, "I do not understand this disproportionate interest in a subject in which my Department has a relatively modest amount left to have any effect on.

And you were absolutely right. Twelve years ago we were funding about 250,000 Medicaid abortions. Today it is someplace between 800 and 1200 a year, mostly for the life of the woman.

My side of this issue has lost that battle. We have lost it on the floor of the Congress. We don't fund very many anymore. Fortunately, most women pay for their own abortions, and fortunately they will continue, hopefully, to have the right to make that choice, the Supreme Court willing.

But indeed the issue became blown out of importance, in the context of the other functions of your office. The questions that people asked, I think, might more appropriately be asked of appointments in the Department of Justice, where we are apparently going to litigate this matter for a number of years more.

Now having said that, I am going to vote for your confirmation, and I am going to vote for your confirmation because, if I were to vote against you, it would have to be on the sole issue of choice on abortion. My side, ever since *Row* v. *Wade* has been making the issue that people should not vote on a single-issue basis. And my side feels the sting more than the other side, because any poll I

have ever seen indicates that those of us who are pro-choice lose more than we gain in the ballot box because the single-issue people vote against us, and for me to retaliate in kind would not be fair.

I think you are a whale of a guy. Anybody who has founded a medical school any place, any time, and raised the money for it and made it go deserves to be in the Cabinet in any position, and especially in this position.

So, you are going to go with my blessing, and I am going to work with you as closely as I can. You are going to have to make some decisions, because of the Administration's position on abortion, that I won't agree with. And those will be fought out on the floor of the Congress.

As a matter of fact, it really wouldn't make much difference whether it was you in this position or Faye Waddleton as the President of Planned Parenthood. Making decisions on the other side, she would make them the way I would like them made, and those opposed to them would fight them out on the floor of the Congress.

There are some decisions left to be made in the family-planning funds area. There are some decisions left to be made in the area of international organizations. But they are going to be beyond your power to add or subtract to, and we are going to make the final decisions. And you have indicated very clearly that you are going to follow the law, as any good public servant should.

With that out of the way, I want to ask about some of the major problems that you are going to have to face.

First, let us come to this idea of a"cut." That definition is a term used only by politicians, as best I can see, not Noah Webster. The average citizen would think "a cut" means less next year than this year.

What the President is talking about in his budget is restraining Medicare increases to about $8.5 billion a year instead of $12-13 billion a year. It is still an increase, by any standard, it just isn't as big an increase as it might have otherwise been.

For you to get those reductions from 13 to 8, which is still an increase, in a "kinder and gentler" fashion, I am curious what you have in mind because I don't know what I would do. I am curious what you specifically have to suggest as to how we can get there, still giving quality medicine, not cutting back on beneficiary rights, trying not to bankrupt the hospitals, treating the doctors fairly.

Dr. SULLIVAN. Well, Senator Packwood, first of all let me thank you for your comments. I very much appreciate your confidence with your earlier comments.

The issue of restraining health care costs is a major one that I think all of us—public servants, health professionals, hospital administrators, and the public at large—have to participate in.

What the President's budget proposes really is a restraint on the rate of increase, as you have said. There are many elements to that. One of the major concerns really is the appropriateness of utilization of services.

There have been a number of studies that have questioned, for example, the rate of surgeries of various kinds—cataract surgery, hysterectomies, and a number of other questions. So, what we have to do, and I believe some studies are underway now, is to determine the effectiveness of the various procedures that we are doing

now. Many of them are high-cost procedures. And having a procedure done isn't necessarily a benefit to the patient; indeed, it may sometimes be a hazard to the patient because of the risks of the procedure.

So, one of the things that we will be looking at very closely in our effort to restrain costs is to make sure that those things which are done are done appropriately and are not excessive.

That is only one part of it. I think there are some administrative issues that we hope to streamline in terms of the overall cost of medical services. But also, as a physician, I can tell you that physicians themselves are going to have to participate in the effort to restrain costs.

I have long maintained that being a physician is really a profession of high calling where one should not be motivated primarily by one's income. I certainly support the fact that being a physician, and the years of training, certainly justify a good income, but certainly not excessive incomes.

So I think that my colleagues in the health professions are going to have to adjust to the fact that we have limited resources. We do have a responsibility to the public to provide those health benefits to which they are entitled, and I think we all will have to participate in this, though I think it is going to hurt a little on all sides.

The CHAIRMAN. Senator Heinz?

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Thank you, Mr. Chairman.

The CHAIRMAN. Surely. You are welcome.

Senator HEINZ. Dr. Sullivan, let me, as with Senator Chafee and others, welcome you and commend you on your willingness to undertake this job. As I think Senator Chafee mentioned, it is quite a financial give-up that you have taken. You must have foregone a lot of sabbaticals in order to build up that equity that is no longer yours. That is quite an up-front contribution to the cause, and we commend you. We welcome you.

I would like to return to a question that some of my colleagues started with, and that is the $5 billion in Medicare cuts that are proposed in the Bush Budget.

I would like to try and pin you down as to whether you support our finding $5 billion. You can call them "cuts," or you can call them "reductions in the increase in the growth of spending"; but whatever they are, it is $5 billion out of what otherwise would be the tab to the Government.

I gather that you have some very specific ideas in mind as to where we are going to get that money. Can you tell us about the source of that $5 billion in savings?

Dr. SULLIVAN. Well, let me say, Senator Heinz, that I think there are a number of things that will be done, though many of the specifics I cannot comment on, of course because I have not yet been confirmed. I have really not had the opportunity to participate in detailed budget discussions.

But as I indicated earlier, one of the areas is restraint on utilization of services. Not all medical services which are provided are

necessary. We have to be sure that we evaluate this and not only restrain inappropriate utilization because of the savings that would occur there but also because of the lack of health benefit and indeed the possible danger to the health of individuals from unnecessary procedures.

Senator HEINZ. The person who has been in charge of the Health Care Financing Administration, Bill Roper, has talked about an effectiveness itiative for some time which is aimed, among other things, at targeting those areas where over-utilization and the use of inappropriate procedures are a problem.

I think it is fair to say that there has been a lot of talk about this initiative, but none of us here certainly have seen any results. Indeed, the Reagan budget proposes that $52 million be targeted toward doing something with this effectiveness initiative; but if it hasn't been developed, how can you use it to implement a cost-savings program? To your knowledge, has the so-called "effectiveness initiative," been fully developed, or is it still languishing some place in the bureaucracy?

Dr. SULLIVAN. Senator Heinz, I can't really respond specifically as to where that is in the Department, but I will assure you that if I am confirmed by the Senate I will promptly review this and find out where it is, and do everything that I can as Secretary to see that this initiative is brought to fruition and indeed is implemented.

Senator HEINZ. I think you will have a lot of encouragement in this from the Committee, because I think we view it as the only feasible alternative to either increasing cost sharing by beneficiaries or seeing the deterioration of the quality of health care to the poor and to the elderly, neither of which, of course, are at all attractive to us or to our constituents.

In terms of what you might be able to save under Medicare, I am going to work off the old Reagan Budget, which has a reduction from current services of some $5.0 billion. Most of that, comes from Part A. Less is to be saved in Part B.

Have you got any sense of what proportion of those savings could be saved in the coming fiscal year, which begins on October first, from better utilization, curtailment of inappropriate procedures, and the kinds of savings that would not affect either necessary patient quality, patient care, or the quality of those services?

Do you have a feel for what you might be able to achieve? You are a physician, you work in a hospital, a medical school, you teach the people who do this. You should have a very good idea about how much can we squeeze out of this lemon.

Dr. SULLIVAN. Well, again, Senator Heinz, I think that I would frankly have to look and work with my colleagues in the Department to try and come up with a specific figure for you. Although I am a physician, my professional activities really don't encompass the whole range of medical services that physicians are providing, as well as the national figures throughout the country. But I certainly will look at this issue and will be happy to discuss this further with you.

Senator HEINZ. One last quick question: You had a very commendable opening statement. You identified all of the areas of appropriate concern for HHS. But if there is one thing you would like

to accomplish, what would it be? Otis Bowen was our Secretary of HHS for about two years. He accomplished one major task, a legislative initiative, that being catastrophic coverage—his and the President's initiative.

Is there one initiative that you would like to accomplish, that would be your special legacy, a special improvement in either the delivery of health care or some other area of your jurisdiction?

Dr. SULLIVAN. Yes, Senator Heinz. There are several.

Senator HEINZ. Just one. I want the top one, if there is one.

Dr. SULLIVAN. Yes. Right.

The top would be greater emphasis and development on health promotion strategies, for this reason: For major improvements in the health status of all of our citizens, given the fact that we do have a restrained budget, that represents the greatest potential investment both in improving health and restraining costs for our citizens.

It also fits with our philosophy in the Administration of promoting self-empowerment of people, giving individuals more control over their own lives and not depending upon others, physicians or other health professionals.

So I think that fits into a larger fabric of welfare reform which is designed to bring self-empowerment and self-direction and autonomy to individuals.

So, health promotion strategies would be the number-one priority in the Department because of the many benefits it could bring to our population, and also because I think it would give us the greatest bang for the buck.

Senator HEINZ. Dr. Sullivan, thank you very much.

The CHAIRMAN. Senator Danforth?

OPENING STATEMENT OF HON. JOHN C. DANFORTH, A U.S. SENATOR FROM MINNESOTA

Senator DANFORTH. Mr. Chairman, let me first say that I very much agreed with the opening comments that Senator Chafee made.

As I understand the arrangement that has been made between Dr. Sullivan and Morehouse Medical School, it is grossly unfair to him and has nothing at all to do with ethics.

My hope is that we can reopen this issue with the White House, and that you, Mr. Chairman, and Senator Packwood and maybe others on the committee could really get into this and find out whether what has been asked of Dr. Sullivan is fair to him. It does not seem fair to me, and I will just voice that as my own concern. I really don't think it has anything to do with ethics or propriety or appearances of impropriety.

You have foregone, as I understand it, benefits that you have earned after long service to Morehouse Medical School. It just doesn't seem right to me.

Now, I really only have one point to make, and it is along the line that others have talked about. I want to talk to you about method rather than specifics.

Clearly, there is some limitation on what the Federal Government can spend for health care. We decided that back in 1983

when we put in place the Prospective Payment system, that we weren't just going to be a check-writing operation here in Washington, there had to be some limits.

What happens in practice is that every time there is a budget, we in the Finance Committee have to wrestle with the question of what to do about the budget, what to do about Medicare and Medicaid.

We end up meeting in this room, back in the back of the hearing room, and making a series of ad hoc decisions based on staff recommendations that don't appear to have anything to do with any kind of broad picture. We are simply clipping out, you know, a few million dollars here or a few million dollars there. There is no sense of putting in place any kind of plan or any kind of policy with respect to health care. We are not facing up to the question of what our Government can afford in terms of health care of what the country can afford in any sort of pro-active way.

Some people might say, "Well, the sky is the limit. The cost of health is something that we should pay to any extent. Health is invaluable." I don't think we can say that as a government, but maybe that is the first question to raise—is there any limit? Or is the sky the limit?

I don't know how to go about this, but you said in answer to an earlier question that you believed—my understanding of your answer—you believed that this is the kind of decision that a lot of people are going to have to participate in making: health care providers, the American public. In a way it is an ethical decision. How much money should be spent to keep people alive for, say, x-number of months.

That is the sort of issue I think should be raised. I don't see it being raised. I don't see this kind of issue being thought out in any kind of conceptual way.

The point that I make—I am not even sure it is a question, but the point that I would make for your response or reflection, any response you would care to make, is: Is there some form that you can think of, some panel of experts that we could put together to try to help us focus on the question of how much are we going to spend and what are we going to spend it on?

If we decide, for example, that we are going to spend x-number of dollars, then it seems that the second level of decisions is do we spend more on prevention? Do we spend less on hospitalization? How do we divvy up whatever funds are available?

I am not asking you to give me the grand plan right now, but your thoughts, if you have some, on how we can reflect on a very broad basis as to where we are going with the cost of health care.

Dr. SULLIVAN. Thank you, Senator Danforth.

As you have indicated in your comments, this is a very difficult question to address, and one where the parameters are very elastic depending upon the participants around the table when such issues are raised.

I think we are facing that dilemma because only in the last few years have we run up against the reality of limited funds being available.

We have had a marvelous biomedical research enterprise in this country, where we can do many things now that were unheard of

when I was a medical student. Kidney transplants were first being done when I was a medical student. They were a novelty then, now they are routine. Heart transplants. We can restore the immune system. We can transplant diabetic eyelet cells into individuals.

So really, what we are faced with is the reality that our marvelous technology and our tremendous biological advances have confronted us now with a serious dilemma; that is, we can do a lot more than we can afford to do.

And at the same time, where we have these capabilities that are very expensive because they require a number of highly-trained people, not only physicians but technicians and others, equipment, et cetera, we still have problems of distribution of basic health services to a significant part of our population. So we really have a competition there.

There are many things that our medically-underserved individuals need that don't cost very much—immunizations, for example, not only against polio but measles and a number of other things—so that I see, frankly, that we have to have an ongoing discussion continuously, with broad participation, not simply ad hoc decisions made on a crisis with a deadline confronting us, but really ongoing decision participation by a number of us. Because in the final analysis, I believe that we have to have a system where our society and our citizens feel that they have had a fair shake, in their views. This is really, after all, not a decision for doctors or other professionals, but it is really a decision for our society. And of course, you as our elected officials play a very key role in helping that decisionmaking process.

So, it really is something that I don't have a specific answer for, but I think it certainly is something that we are going to be confronting from now on.

Senator Dole?

OPENING STATEMENT OF HON. BOB DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. Thank you, Mr. Chairman.

First, I would like to include in the record a statement in support of the nomination, which I would ask be made a part of the record.

The CHAIRMAN. Without objection, Senator.

Senator DOLE. Secondly, I want to thank Senator Packwood for his magnanimous statement. I think it is typical of Bob Packwood.

And to associate myself with the remarks of Senator Baucus, except for the 55 degree below temperature, and the fact that the car wouldn't start. That is a bigger problem. But, in any event, we do have a number of rural hospitals and a number of real problems. And I am certain, as you address the concerns of Senator Baucus and others on this committee, we will have a lot of contact with you on that particular issue.

I would also associate myself with the comments made by a number of members on the issue of severance pay. As I understand the issue, because Morehouse receives federal funds, that creates a problem with you as Secretary of HHS.

I would hope that the committee might in some way indicate that it is not a matter of integrity or a matter of ethics, and it

might be reviewed by the White House or whoever might be appropriate, because it does seem to me that it is an unfair sacrifice to ask anyone to make. And if there is some conflict that we don't understand, maybe we can at least take a look at it. But I certainly associate myself with those remarks.

Also, I think it is fair to say that you may have learned there are a few cynics in this town, and they are not all in the media. And there are some who say, "Well, the only reason that Dr. Sullivan is going to be approved is he is the only Black appointed by President Bush, and therefore he will get through."

I think it would be very helpful to this committee to know—and I think you do know—why you were chosen by President Bush.

Dr. SULLIVAN. Thank you, Senator Dole. I really appreciate your raising that question, because let me say this: First of all, I believe and I hope that I was asked to serve in this position by President Bush because of my qualifications—what I can bring both as a physician and because of my life experiences, and the kinds of concerns and commitments that I have, to really helping the Department and helping the President and members of the Congress really provide those services to the American people that are owed to them.

I think that the fact that I am Black should be incidental. But I also do represent an important constituency. I believe that we have a Government that, to work best, must have representation of all segments of our society. And certainly, having been very active in the Black community and knowing the concerns and the problems in that community, I think I have a special sensitivity there; but I have a broader sensitivity, which encompasses looking at all segments of our society.

For example, at my medical school, while we say that we are predominately Black, we have White students, Hispanic students, Native American students, and foreign students as well. The reason that that is important is that our students learn to work with each other. They learn from each other. They learn the different societal and cultural norms, the sensitivities that are important for a physician to relate to his or her patient, the many subtle things that make a big difference to that patient, and the quality of that physician-patient interaction.

So indeed, I believe, and I certainly hope, and I would certainly urge this committee to look at me for the qualifications that I have and that I bring to this position. Certainly I am Black. I am proud of that fact. But I think that I am equally if not more proud of what I have been able to accomplish and what I would hope to accomplish as the Secretary of Health and Human Services if confirmed by this committee.

Senator DOLE. I think that is an excellent statement and one that we all share. In my view, you are here because of our qualifications. You were chosen for that reason. But I have read, very honestly, as you have read, that, "Well, he is the only Black nominee, so the Senate will overlook certain things." That has not been the case.

Certainly, as you understand, you have been asked some tough questions, and you have gone through all the rigors of confirmation that nearly every other nominee has, and we appreciate it very

much, and appreciate your willingness to come in to public service, even without the pay raise that was out there, early on, as you may have been considering this. [Laughter.]

But I certainly look forward to working with you, as I am certain other members of this committee do. It is a tough job, probably the toughest job in town—or one of the toughest, next to Labor, or course. [Laughter.]

But in any event, we are also here to help in addressing some of the problems, and I thank you very much for committing yourself to public service.

Dr. SULLIVAN. Thank you, Senator.

The CHAIRMAN. Senator Pryor?

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Thank you, Mr. Chairman.

Dr. Sullivan, many of the areas of questioning such as rural health care and Medicare budget priorities, et cetera, have been addressed by my colleagues. I would like to say this, and I don't think it is in the form of a question:

I don't know who you are going to name to some of these very, very key, critical positions, HCFA, for example, is a position that is going to affect health care for every man, woman and child in this country. I don't know who you have in the back of your mind. I don't know whether that decision will be made by Dr. Sullivan—where I hope it is made—or whether it will be made in the White House. I hope it is made by you.

Likewise the Social Security Administration, if they change that position—is a similarly critical appointment. Other important agencies under you include the Administration on Aging and the National Institutes of Health, and so on.

I would just like to say this, if I could. There is nothing written in granite that the key people you name have to come from inside this beltway.

There is a great reservoir of talent in this country of ours, willing, able, committed to do something about health care and the delivery of those services that you are going to be challenged to provide, that don't live in Washington, D.C., that have never worked for an agency or a bureau or even for the Federal or even the State Government.

I would hope, for example, in HCFA that you might consider someone who has experience administering health care in a rural setting. You know these people, because you have been in the trenches with them. And many times I think we do lose sight of the real world here. I hope that you will not lose sight of the fact of this reservoir of strength, of support, that would be, I think, a breath of fresh air at HHS.

Also, Dr. Sullivan, I would like to compliment President Bush for choosing a man who was not in the Washington establishment. I think that was a very, very good move. I think he went out and got some real people in bringing you in, and I hope you will complement that decision by strengthening—not weakening but strengthening—your Department by going outside the Beltway to find some

people who are out there who know these problems and possibly who can cut through the bureaucracy and get down to what is really important.

I just wanted to make those comments to you, sir.

One other final thing—and I guess I have a minute or two—once again, not in the form of a question: We are all grown men around this table. And sometimes I think that people come before us and try to fool us with figures that don't exist or fantasies that we know cannot be accomplished.

I would like to say, as just one member of this committee, I hope that you will feel close enough to us that you can come back in that room and level with us, and say, "Look, I have got a problem," or, "Look, we are basing this budget on wrong figures," or, "I didn't know who prepared this budget," that "so-and-so's program was cut," or, "We don't need this program," or "Do need that one."

I hope that we will have that kind of frankness in that relationship, because most of us have been around here for a while, and I think we would appreciate that honesty and that frankness.

I look forward not only to voting for you but to working with you in this enormous, awesome role that you are undertaking.

So, if you want to comment to any or all of that, I think I have maybe a few seconds left. Thank you, sir.

Dr. SULLIVAN. Thank you very much, Senator Pryor, for those comments, and let me respond.

Certainly I look forward to working with you and the members of this committee in tackling problems that we will be working with you on, head-on. I will certainly give you my best judgment about the problems that we face, and certainly seek your judgment and your help as well.

Let me also comment on the issue of personnel, because I have been concerned by some of the reports that have suggested that I have not been making the selections for the people for my Department. Let me assure you that that is not the case.

There were two commitments that I asked President Bush when he first spoke with me about this position, and one of those was that I would name my own people. That commitment has been honored thus far by him.

I think it is a disservice to me as well as to the people I have chosen to suggest that they have been chosen for reasons other than their competence and what they can provide in leadership and help to the Department. And that is the basis for that.

Certainly, for every position that we have, we are seeking the best people available, because we know that we have difficult problems to face, difficult decisions to make. And in order to make those decisions in the best interest of the American people and to serve you and the President well, we have to have the best minds and the best information available. So certainly we are going to do everything we can in those selections, in bringing the best people we can get to work with us.

Senator PRYOR. Thank you, Dr. Sullivan.

Dr. SULLIVAN. Thank you very much.

The CHAIRMAN. Senator Mitchell?

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Thank you, Mr. Chairman.

Dr. Sullivan, I join the other members of the committee in welcoming you. I intend to vote for you. I think your choice by the President was a good one, and I wish you the very best in what will be an important but extremely challenging and difficult task.

You are aware, I am sure, of the great deal of good that you could do in the position you will soon assume.

I ask, Mr. Chairman, that an opening statement of mine be placed in the record.

The CHAIRMAN. Without objection, that will be done.

Senator MITCHELL. I want to ask you just a couple of questions about some specific issues. If you are not personally familiar with them now—that is understandable—I would ask that you respond in writing at your earliest opportunity, if you choose to do that.

Last year, after years of debate, we finally enacted legislation on welfare reform. The bill created a new jobs program for welfare recipients which called for $800 million in funding in Fiscal Year 1990, in the form of a capped entitlement.

The Reagan Budget recommended $350 million in funding for that program; the Bush Budget is silent on it. And I ask you whether you are aware of that and, if you are, what your views are, and whether or not you will undertake to press for welfare reform to be meaningful as intended when the Congress enacted this legislation, to continue this jobs program, which is an important component of that program.

Dr. SULLIVAN. Thank you very much, Senator Mitchell.

Let me say, indeed, that implementation of the welfare reform legislation I have identified as one of my first and highest priorities, and we will be working to implement that vigorously because of the fact that it has some very important features in it.

First of all, the self-empowerment of people—giving them skills, job training, et cetera—and also giving impetus to the responsibility that parents have to their children. Certainly, child support provisions of that, we feel are very important, both because of monetary reasons as well as the responsibilities that parents and particularly fathers have to their children.

It is my understanding that the $350 million sum was felt, both by the Congressional Budget Office and the Office of Management and Budget, to be the sum that could be reasonably spent during the first year of implementation of the program.

I do understand, however, that there is a legitimate question as to the appropriateness of the procedure here that has gone into this figure. Certainly, if I am confirmed by the Senate, I pledge to work with you and the members of this committee and my colleagues within the Administration to try and clarify this issue so that we can get on with welfare reform legislation.

Senator MITCHELL. Well, the first thing you can do is to get the Administration to tell us whether they support this or not. This is one of the areas in which the Administration's budget is silent. So there is no way of knowing it. It is in one of the group of programs which Mr. Diamond has said are not a priority for this Administra-

tion, and we can take them all together in the so-called "black box."

What I am saying to you, speaking only for myself, but I believe many members of the Senate feel, is that that was an important, landmark piece of legislation. We think it is a priority, and we hope you will work to persuade the Administration that it is so.

Now, one other area in which I was involved, serving previously as Chairman of the Subcommittee on Health, was in what is known as "outcomes research." I don't know if you are familiar with that, but I developed legislation last year to authorize funding for outcomes research and am currently working on a new bill to give additional support and direction for that type of research in your Department.

Secretary Bowen and Dr. Roper were extremely supportive of our efforts in that regard, because it is important to expand the base of knowledge about the effectiveness of medical decisions, particularly for Medicare beneficiaries.

I would like to ask you to look into that and, if you will, indicate to me your view with respect to outcomes research, and hopefully I am seeking your support in that regard, as Dr. Bowen supported the effort.

Dr. SULLIVAN. Yes, Senator Mitchell. Many of the details here I have yet to learn, but let me say that I am familiar with the thrust of the legislation and its purpose, and I fully support that. In other words, we need to know if what we are doing is indeed effective and is better than other alternatives, as well as comparing the cost of what we are doing.

So we certainly are very supportive of that kind of research, and, if I am confirmed by the Senate, I will be working with my colleagues within HCFA and the Department to see that we move that research along.

Senator MITCHELL. All right.

Just in the closing few seconds I want to express one concern: The so-called "Budget Summit Agreement" in late 1987 required reductions in Medicare of $5.5 billion over the ensuing two-year period.

I, along with Senator Bentsen and others here, was involved in implementing those reductions, and we attempted to do so in a manner that was as fair and equitable to all concerned as possible, nonetheless recognizing that it was difficult to absorb, particularly by hospitals.

I know the Administration's budget calls for a $5 billion reduction in Medicare in the next fiscal year, unspecified, and we will have to decide that. I just want to say I think that is going to be very difficult for many of the providers, particularly the hospitals, who are facing serious problems now.

I encourage you to work with us in that regard, as Dr. Bowen did on behalf of the previous Administration. I don't know what we are going to end up with. I have to say, candidly, I doubt we will achieve the $5 billion level of reduction, although there clearly will be some, and I don't know where it is going to come.

But I ask you to familiarize yourself with the difficult circumstances facing many hospitals, because one of the critical components of the effective delivery of health care in our society is of

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course a viable and financially-sound system of hospitals available throughout the country.

Dr. SULLIVAN. Yes, Senator Mitchell. I am concerned about the escalation in medical care costs in the country and have mentioned earlier the fact that I think all of us, health professionals and others, are going to have to participate in strategies to restrain the costs.

Dr. SULLIVAN. Yes, Senator Mitchell, I am concerned about an absolute increase of almost $9 billion in our budget. So that what we are trying to do is indeed provide the services that our citizens need, but at the same time we are mindful of the Federal budget deficit as well as other national priorities that we have to address and the fact that although we spend the highest percentage of our gross national product of any major industrialized country on health care, we rank, I believe, somewhere nineteenth or twentieth, in the world in terms of infant mortality. So, costs are not the only issue that we have to address. We really need to look at how we are organized in providing that care and the efficiency and the appropriateness of utilization.

But I will assure you that I look forward to working with you and your colleagues to try to do everything that we can to preserve the system of our hospitals and our physicians. But, at the same time, have to be mindful of the costs that are involved.

Senator MITCHELL. Thank you very much, Doctor. Our votes will be with you and given the magnitude of the task you face, perhaps more importantly, we will pray for you, too.

Thanks a lot.

Dr. SULLIVAN. Thank you.

The CHAIRMAN. Dr. Sullivan, on the point that was raised by Senator Mitchell, I share very much his concern over it, specifically the question of the amount of money that is to be expended for education and training for welfare recipients under the Welfare Bill.

You alluded to it in a rather bleak way I suppose when you said there was some controversy over procedures. If you are talking about whether or not it is a discretionary program or an entitlement, I could not agree more, because this was passed as an entitlement provision. And in less than three months after that passage the Administration's budget was presented to us undermining that entitlement feature and capping it at $350 million, turning it over in effect to the Appropriations Committee and making it a discretionary program. I am deeply concerned about that.

I want you to focus your attention on it, if you will. I am not asking for an answer on that today but I want to emphasize, and several of us do, that entitlement feature in the legislation as it was passed—and that funding was $800 million to try to see that these welfare recipients are able to get off welfare roles and fulfill jobs.

Dr. SULLIVAN. Yes, Senator.

The CHAIRMAN. We have another witness yet and we have a number of committee things to dispose of. So, unless there are further questions we will move on.

Senator ARMSTRONG. Mr. Chairman, I have a number of questions that I would like to propound to the witness.

The CHAIRMAN. Senator Armstrong.

Let me state, I have a number of other questions particularly on children's programs that I will submit to you in writing.

[The questions appear in the appendix.]

Senator DURENBERGER. Mr. Chairman, I have not been recognized yet, either.

The CHAIRMAN. I beg your pardon.

Senator DURENBERGER. I said I have not yet been recognized yet.

The CHAIRMAN. That is because you were not here in your sequence. But I will get back to you.

Senator Durenberger. Oh.

The CHAIRMAN. All right. Senator Armstrong.

OPENING STATEMENT OF HON. WILLIAM L. ARMSTRONG, A U.S. SENATOR FROM COLORADO

Senator ARMSTRONG. Mr. Chairman, I want to join my colleagues in welcoming Dr. Sullivan and, Doctor, I congratulate you on your statement which I appreciate very much. I thought it was very useful and I have also listened with interest to your response to the questions of my colleagues.

I have two or three questions, or I should say two or three areas of interest in which I would like to ask several questions. I would like to start by asking you to comment on some Social Security related matters. You mentioned the Social Security System in your initial statement. I wonder if you could tell us at the outset what your understanding is of the role that you will play in formulating Administration policy with respect to Social Security.

Dr. SULLIVAN. Well, Senator Armstrong, of course the Social Security Administration represents some 60 percent of the budget of our Department. We are very concerned about the fact that it is preserving the income for our older citizens as well as providing disability programs for many of our disabled citizens. So we intend to play a very active role in developing policies to preserve those funds for our citizens. We intend to work with my colleagues in the Administration and certainly with you and the Congress to see that citizens do get the benefits to which they are entitled.

Senator ARMSTRONG. Would you be the person who would be the chief spokesman on Social Security issues for the Administration?

Dr. SULLIVAN. That is my understanding, yes.

Senator ARMSTRONG. And would you be the person who would ordinarily present the President with recommendations on proposed changes in Social Security?

Dr. SULLIVAN. Yes, along with my colleagues in the Department. Certainly I would depend very significantly on the Commission of the Social Security Administration and their colleagues. But certainly I would be the lead spokesman and active participant in those discussions.

Senator ARMSTRONG. Doctor, are you familiar with the Social Security earnings limit as it now exists?

Dr. SULLIVAN. In a general sense, yes.

Senator ARMSTRONG. Well, then as you know, at the present time if a person's income exceeds $8,880 a year from non-Social Se-

curity sources, then after that limit is reached they forfeit $1 of Social Security benefits for each $2 of outside income they receive.

This has been a subject of great legislative interest by members of this committee and others. And in fact, along with a number of other members of this committee, I have introduced legislation which will phase out and ultimately repeal this earnings limit. I guess there is no way to know for sure, but it is my impression that probably if you were to poll Social Security recipients around the country that that is probably the number one issue that would come up spontaneously as a source of concern to them.

I also was very much impressed when, in his inaugural address that Mr. Bush made the following observation. And let me just quote, because he said it better than I can. He said, "We must bring in the generations, harnessing the unused talent of the elderly."

The reason I draw your attention to it is this. My initial interest, which goes back a number of years, in abolishing the earnings limitation was simply the justice of it. It just seems unfair to me that if you are over sixty-five and drawing Social Security that you should be subjected to a higher rate of marginal tax than any other citizens in our country.

In fact, it is not hard to imagine that if you are paying income tax, both to the Federal government and to the State government, and then are docked $1 on your social security for every $2 you earn, that the practical effect is you get a marginal tax rate of not just 50 percent, but maybe 75 percent, maybe 90 percent. I am told that in a few extreme cases, you might actually face a marginal tax rate in excess of 100 percent. So my interest in it is that it is just unfair.

But beyond that, it seemed to me that Mr. Bush was making a point we need to think about, which is that with the changing demography of the country, we need the contribution of work and effort that senior citizens can make. I am intrigued that we see a lot of persons beyond so-called normal retirement age who are working in occupations formerly we thought of for teenagers, like at the McDonalds and the Wendys and so on. Frankly, I think that is a good thing. I think that many elderly people need the activity as well as the money that they earn.

So my question is to you, have you focused on this issue and can you tell us how you feel about it at this point? When the President consults you for the Administration's position, will you be in a position to advise him and what advice would you give?

Dr. SULLIVAN. Well, Senator Armstrong, thank you for that question. Let me say this, the specific details I would have to defer until I have reviewed this with my colleagues in the Department.

However, let me say that I fully agree with you that we need to harness the energy of our elderly citizens, not only because of what they can contribute to our society, but also because keeping them active is a very real benefit to them in terms of their health and well being. Having productive activities that will give them something worthwhile and useful to do are worth their time.

So I certainly would do everything I can to promote policies that would encourage our elderly citizens to contribute their time and talents to our economy because that is good for the economy as

well as good for the citizens themselves to be actively, continually involved.

Senator ARMSTRONG. Mr. Chairman, I am going to record Dr. Sullivan as leaning favorable to this proposal. I am not going to press him any further on this matter because this is not something which I have discussed with him previously. I judge that he perhaps would not be wise to get completely locked in until he has had a chance to talk to the Secretary of the Treasury and the Director of OMB, and maybe the President. But I did want to raise it.

There are some other matters, Mr. Chairman, I want to pursue on which I have spoken previously to Dr. Sullivan and which I will hope he would be more specific. But would it be your desire that I yield now to let other questions take their turn?

The CHAIRMAN. Yes, it would. Thank you very much.

Senator ARMSTRONG. May I then be recognized for a second round?

The CHAIRMAN. Yes, Senator. But I must say to you, Senator, we have quite a number of things to complete here. I do not want to cut you off.

Senator ARMSTRONG. Mr. Chairman, I assure you that the questions I have to ask are significant and important, and are not frivolous, and I will not waste the time of the committee.

The CHAIRMAN. Senator, I have never heard you ask frivolous questions. I do not charge you with that.

Senator Durenberger.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Thank you, Mr. Chairman.

Dr. Sullivan, I join in the welcome which I think gets warmer as your responses illustrate to this committee in particular that you are willing to acknowledge that we all have something to learn about this process.

One of the interesting things about this committee is that, I think, with maybe four exceptions, everybody on this committee has been dealing with these issues since 1979. And so when the Chairman and some of our colleagues here invite you to test us out from time to time, I suspect that it would probably be a very appropriate thing for you to do. I appreciate the fact that in your rounds you have done that.

I also thought it was very interesting this morning, and I hope it is to everyone who has been observing this process, that most of the questions were on health care. They were not all on Social Security. Senator Moynihan has not even been here most of the morning to ask you about Social Security or welfare reform.

The CHAIRMAN. Oh, Senator, he was here while you were not here. [Laughter.]

Senator DURENBERGER. Can I charge that to his time?

But to just the prevalence of questions about how are we going to meet the high costs of health care in this country I think indicates that the President was wise in choosing somebody with your background and your experience and a commitment that I think we all

now know comes from the heart as well as from the head to do something about these problems.

But, like all things, it is the kinder, gentler George and in this case, Lou, meet the deficit. I listen to your response to Senator Heinz about what would you like to be remembered for, it is prevention and wellness. I have to tell you, for five years we have been trying to do that here and you cannot do that. You cannot do it up against the deficit, see, because it costs money to save money. The system will not let us do it.

I listened to your response to George Mitchell on quality and outcome. Well, we need to spend some money on the basic research, the data gathering, to get us to the point where we can measure quality and not let malpractice insurers try to measure quality for us or things like that. But it costs money to do that and the deficit will not let us do that.

I think I could go—as all of the people on this committee could—through a variety of things we have to do in this country if we really believe in restraining the cost and retaining the essence of the quality of the system. We always find out that when we get to the backroom, as Jack Danforth was saying, or the green tablecloth in the frontroom, we cannot do it.

So it seems to me your major challenge is going to be responding to the questions about who is going to speak for the President. Is it going to be the doctor who started the first medical school, or the only one in this century, and who feels these things so deeply? Or is it going to be the green eyeshades that OMB or some other place?

That is a major challenge in which all of us on this committee in particular—since we are the ones who have to come to your leadership—we are the ones who also want to be as helpful as we can be in your meeting that challenge.

Now I have a long series of nonfrivolous, high quality, incredibly meaningful—and if we had time for the audience—impressive questions to ask you. [Laughter.]

Your colleagues in the Association of American Medical Colleges asked me last night a variety of questions like, with indirect teaching at 7.7 percent and we are still going in the hole in our medical schools, how dare you think of cutting it to 4.05. you are going to have to answer that one for them.

Questions on going to PPS in part B and your feelings about that as a physician. The problem of the uninsured which we are now undertaking at a bipartisan commission and long-term care.

And then something that no one has brought up before that I hope you will take the time to respond to. That is, it has been called the nurses shortage. But what it really is in this country is a shortage in the sense of reality in the way we look at nursing as a profession. We are all going to get hit during the course of 1989, especially in our little rural hospitals and our little rural nursing homes and so forth. We are going to get hit with the reality that nurses are going to want something by way of a return for the effort of the contribution that they make. They are going to demand it in salary and other things. It is going to hit us all this year.

I hope that we at this level, and those of us who through leadership position have some influence on the rest of the system in this country, are going to be prepared to give some leadership in this very vital area. So those are the kinds of questions I will ask. Mr. Chairman, I thank you for this opportunity and I thank you for the way in which you have conducted, not only this hearing, but the whole process leading up to Dr. Sullivan's confirmation process.

The CHAIRMAN. Thank you very much, Senator.

Senator Armstrong.

Senator ARMSTRONG. Thank you, Mr. Chairman.

Dr. Sullivan, in December some newspapers articles characterized your position on abortion in ways which did not upon examination prove to be entirely accurate. I do not want to go back into abortion, but I do want to direct your attention to a newspaper article which occurred on December 18 in The Atlanta Journal.

In that article you were reported as favoring fetal experimentation. Was that article accurate and do you, in fact, favor fetal experimentation as reported in that article?

Dr. SULLIVAN. Senator Armstrong, as I recall that interview, when that issue arose I expressed, at that time as I have continued to express, reservations about any blanket prohibition concerning research because—as I indicated in my opening statement—we have as a society reaped the benefits in improved health care and new technologies as a result of our broad research effort.

On the specific issue of fetal research, this is an issue that I know has had a commission reviewing it. It is working its way through the Department. And it is a concern that I will have to address if I am confirmed by the Senate. I really want to review those recommendations and all of those perspectives once they come to me as a result of all of the hours of deliberations by the members of that committee and the various review levels in the Department.

I think that my concerns, which I expressed, were really a blanket prohibition concerning research in general because I think that is very dangerous. But I was not endorsing fetal research but simply expressing a caution concerning blanket prohibitions on research. As you know, there has already been agreement that research on the fetus that is of benefit to the fetus is appropriate. I think the other issues here are ones that really are addressed in the committee's report, that I really do want to review in its entirety and get all of those opinions before forming any judgment.

Senator ARMSTRONG. Thank you, Doctor.

Is an induced abortion of relevance? Is the nature of the abortion which leads to the availability of a fetus for potential research, is that an issue that is relevant to your decision making?

Dr. SULLIVAN. Yes, it is. I would certainly not want to do anything that would encourage abortions to be done in order to get fetal issue. I think that no thinking scientist or a physician would really want to do that. That certainly, I think, would be something all of us would find very distasteful.

Senator ARMSTRONG. I think you have almost answered my follow on question about that. But let me state it anyway because it is a very significant one.

I am told that there are some women who have indicated that they might deliberately seek to become pregnant and then to have an abortion so that the fetus would thereby become available for fetal research or for commercial exploitation. I take it from your previous answer that you would not approve such a process and, in fact, would oppose it from what you said.

Dr. SULLIVAN. Yes, I would find that ethically unacceptable and certainly would not do anything to encourage those kinds of decisions being made.

Senator ARMSTRONG. Dr. Sullivan, as you know, last March, Assistant Secretary Windham, issued a directive to the National Institute of Health, which in effect puts a moratorium on the use of fetal tissue from induced abortions for research. Again, I think you have strongly implied what your response to this will be, but let me ask it anyway. Am I correct in assuming that you would continue such a moratorium, that is the moratorium on the use of fetal tissue from induced abortions as specified in Assistant Secretary Windham's order?

Dr. SULLIVAN. Senator Armstrong, I believe that is one of the key issues that the adhoc advisory committee considered. I have not seen that report, but I certainly have read newspapers reports that indicate that this committee feels that if there are appropriate barriers that are erected between the decision of a woman for an abortion and what happens to the tissue subsequently, that there may be some instances where that tissue may be used for research.

Senator ARMSTRONG. When is the commission scheduled to report?

Dr. SULLIVAN. I believe the report is momentarily. But I have not yet seen the report.

Senator ARMSTRONG. Prior to the time that the report arrives, or is considered, or acted upon—and I guess I do not know exactly what form of action is required or contemplated—what will your policy be about the moratorium between now and the time the report is received?

Dr. SULLIVAN. My policy would be to continue the moratorium. I think that would be the appropriate thing to do.

Senator ARMSTRONG. What happens when that commission report reaches you? Is it literally just a report or is it something that requires a decision by you or by others?

Dr. SULLIVAN. It would require a decision by me and the recommendation to the President on that. Because what is involved here is, again, the question of there being an ethics advisory board for human experimentation and a number of medical research activities that are prohibited without such an ethics advisory board. So I think that is one of the key issues that the report addresses.

Senator ARMSTRONG. Doctor, you have indicated that it is your view that it is improper to use the fetus that is the product of an induced abortion for research. I assume you would feel the same way about transportation?

Dr. SULLIVAN. Transplantation?

Senator ARMSTRONG. The transportation of such a fetus. In other words, or even the commercial exploitation of a fetus in such a circumstance.

Dr. SULLIVAN. Certainly on the issue of commercial exploitation, I would certainly agree that that would be totally inappropriate. But let me try and be clear about my position.

My position is, I would certainly not do anything to encourage abortions being done for the purpose of acquiring the tissues for research. On the other hand, turning the issue around, if abortions have been done for reasons totally unrelated to research—I think that is a question that is among the issues that the committee is looking at and will be coming to me for review.

So I hope I am being clear here. Certainly, induction—anything that would induce, or encourage, or promote abortions—I would certainly be against.

Senator ARMSTRONG. Doctor, my final—

The CHAIRMAN. Thank you, Senator.

Are there other Senators that have questions?

Senator PRYOR. Mr. Chairman, 30 seconds to just make a request for something to be included in the record. We have not spent a lot of time this morning on long-term health care.

Mr. Chairman, I would like to request respectfully of Dr. Sullivan to place in the record where you think we are with long-term care, what you think our goals should be, when those goals should be met, the relationship between private industry and the Federal or other governmental entities, and a general overview of what you think within the budget constraints that we might be able to accomplish together. In other words, a general outline of where you think you will come down on this issue.

That is all, Mr. Chairman.

I thank you, Dr. Sullivan.

Dr. SULLIVAN. Thank you.

The CHAIRMAN. Are there other questions other than Senator Armstrong?

[No response.]

The CHAIRMAN. Senator Armstrong.

Senator ARMSTRONG. Thank you, Mr. Chairman.

Dr. Sullivan, when we met I guess four or five weeks ago in the office of the Republican leader, I called your attention to an executive order which had been drafted and I guess had worked its way through various bureaucratic processes and had been studied and approved by the Department of Justice and others. It is generally titled, "The Equal Protection of Children Order" and it goes to the question of the policy of the government with respect to the matters we have just been discussing. That is, induced abortions and transplantation and commercial exploitation and so on.

I assume that you have looked at that executive order and are familiar with the contents of it. My question is, will you recommend to the President that he sign that executive order?

Dr. SULLIVAN. Senator Armstrong, what I would like to do because this really is a very important and very complex question, I really have not had the benefit of the report of the advisory committee concerning the use of fetal tissue. I would think that the best answer I could give would be to review that and really look at all of the recommendations coming from the members of that committee given the hours that they spent in deliberating a very diffi-

cult issue. After reviewing the report, then I will try to give my best judgment and recommendation to the President.

I think for me to prejudge this issue before I have had an opportunity to examine the report would not be the best possible decision that I could make.

Senator ARMSTRONG. Doctor, do you remember our discussion of this matter? Do you remember my telling you that you ought to be prepared to tell us how you felt about that regulation?

Dr. SULLIVAN. Yes, Senator.

Senator ARMSTRONG. Well, Doctor, I guess this is not an issue, but just as a foundation for what I am going to ask you next, let me inquire, do you think it is a proper function of this committee to inquire of your views on major policy issues?

Dr. SULLIVAN. Yes, it is, Senator.

Senator ARMSTRONG. Do you think it is a proper basis on which a Senator should decide whether or not he wishes to vote for or against the confirmation of a nominee based upon the opinion of the nominee on such an issue?

Dr. SULLIVAN. Well, I am not sure that I really follow or understand the issue, Senator. What I have tried to do is to give you my best view on this.

Senator ARMSTRONG. No, what you told me is, that you are reluctant to give me your view at this time. Let me approach it from a slightly different direction. I read in the newspaper, The New York Times, I think, that you have been rehearsing answers to questions submitted to you by a team of interrogators in preparation for this hearing. Is this one of the questions that was the subject of a rehearsal at such a session, questions relating to this proposed regulation.

Dr. SULLIVAN. No, this was not a question, Senator. But what I have tried to say to you is this, that this is a very complex issue that we have had a committee appointed that has spent many hours in looking at these issues. And really, it would, I think, be a circumvention of that procedure and the many hours that have been spent with input from many individuals for me to try and second guess that committee and to really make a decision without the benefits of the activities of that committee.

Senator ARMSTRONG. Well, Doctor—Of course, you do not have to tell us anything you do not want to. It is not probably going to change the outcome of your confirmation. But the reality of it is, that if there is meaning and significance in this process, it is to elicit your views and also to understand the way in which you make decisions.

Now more than a month ago I suggested to you that this was an issue that was of interest to me and I imagine that it is of interest to other Senators. I think it was of interest to other Senators who were present in the room and I imagine that there probably even Senators who were not in the room, who would be interested first to know your views on this matter and also your habits of mind about making decisions.

I am not suggesting this is a simple decision. But it is not a terribly complex decision. It is a controversial decision. That I would grant. But the questions involved here are contained on one page,

which has been published in the Congressional Record. It is not something that is 1,000 pages.

It involves some very simple, basic questions and those questions are whether or not it should be the policy of the Federal government to use these tissues and under what circumstances. The actual sections of the order simply say, "It is the policy to the extent permitted by law"— over and above the law—"to respect the humanity and dignity of living unborn and newborn children and to protect them from having organs removed ..." And the question of whether or not the tissues of an induced abortion fetus may be used in certain ways.

It just seems to me that for someone of your vast experience in medicine, having looked at this matter, you know all your life really, and having had it forcefully drawn to your attention by the news media, gently, but I hope firmly by me, that for you to come before the committee and say, no, I am not going to tell you how I feel about that, you are just ducking the question. Is there something I do not understand here?

Dr. SULLIVAN. No.

Senator ARMSTRONG. Well, when would you tell us?

Dr. SULLIVAN. Well, Senator, what I have already indicated to you is that I certainly do not feel that it is appropriate for me or anyone else to take any actions that would encourage women to have an induced abortion for the purpose of obtaining tissues for research.

Looking at it from the other side, this committee as I understand it, which has been working for many months, had as one of its responsibilities to look at the question of when, if ever, is it appropriate and under what circumstances, for such tissues to be used for research.

And what I am indicating to you is, I believe that as a responsible public official I should, indeed, consult with the broadest array of individuals possible, and certainly would consult with you and other members here in the Congress. This is an issue that has been working its way through the Department through the Committee, and until I have had an opportunity to review and to receive the many faceted advice from that Committee, it would be best that I not take any position.

Senator ARMSTRONG. Mr. Chairman, I think I have pursued it about as far as I can. But let me just close by saying, Doctor, it is not my purpose to harass you. In fact, when we talked about it, I made a point of telling you that I would not sandbag you. That I wanted you to know in advance that I was going to ask this question or a series of questions on this matter.

And basically what you have decided to do, after having had a month to read this, to consult anybody you wanted to, to talk to somebody, to pray about it, to get a wiege board, anything you wanted to do, basically what you have decided is, that you are not going to tell me or this committee how you feel about this issue. Now that may be very astute politically.

Because if you say you are for the regulation, which is not complicated. Let us not kid yourselves. We are not talking about a complicated matter here. We are talking about something which is easy to understand for any person, let alone someone of your vast

experience. Now, if you come down on either side of this, you are going to bring down some criticism on you one way or another and at some point you will probably have to do that.

But, Doctor, you are not up for confirmation to be an appellate judge. You are up for confirmation to be a manager of a very complicated Department that probably has more constituencies who are better organized and are tougher and more skillful in advocating their point of view than any Department there is. And you are going to have to make decisions like this seven days a week. And for you to come before the committee, especially when you have had a month's warning, on this issue of great sensitivity and just say that you are not going to tell us is a great disappointment to me.

I thank you for your courtesy. But, I would be a lot less than frank if I just did not tell you that that is not good enough as far as I am concerned. I am disappointed.

Mr. Chairman, I thank you for your courtesy, sir.

The CHAIRMAN. Thank you.

Dr. Sullivan, on another question, and that is the one of your accrued benefits and some of the comments that have been made here. In looking at the statute on supplementary pay when people are drawing Federal salaries, or cursory examination of it, it appears to me, that this is not the usual ruling when you have already accrued the benefits. I question the equity in that. It concerns me the sacrifice that is being made here in something where it is already yours and you, in effect, have paid for it in the past.

So I am going to further probe that and get back to this committee concerning it. We will give that further consideration. I want to be sure that what we do is right, but I feel that what is being asked of you has not been asked of others in the past. I do not want you to have to accept undue sacrifice. If within the spirit of the law, and in ethics, you are complying without that sacrifice.

Dr. SULLIVAN. Thank you, sir.

The CHAIRMAN. Thank you very much, Doctor. We are pleased to have you.

We have another witness yet to be heard.

Did you have any further comments?

Senator PACKWOOD. No more questions, Mr. Chairman.

The CHAIRMAN. Any further comment?

Senator ARMSTRONG. No. Thank you, Mr. Chairman.

The CHAIRMAN. All right.

Thank you, Dr. Sullivan.

Dr. SULLIVAN. Thank you, Mr. Chairman.

The CHAIRMAN. What I am saying, Dr. Sullivan, I am going to further probe that one with the members of this committee and see what we can do about it.

Dr. SULLIVAN. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is Mrs. Judie Brown, President, American Life League, Stafford, VA.

Mrs. BROWN.

STATEMENT OF JUDIE BROWN, PRESIDENT, AMERICAN LIFE LEAGUE, INCORPORATED, STAFFORD, VA

Mrs. BROWN. Mr. Chairman and members of the Finance Committee staff—

The CHAIRMAN. Mrs. Brown, would you please limit your oral statement to five minutes. We will take the entire statement in the record.

Mrs. BROWN. Yes, Senator.

The CHAIRMAN. All right.

Mrs. BROWN. My name is Mrs. Judie Brown. I am the President of American Life League, Incorporated. Our national headquarters is located in Stafford, Virginia and our membership represents 200,000 families across America.

I am here today to oppose the nomination of Dr. Louis W. Sullivan as secretary for the Department of Health and Human Services. It is clear from the posturing that Dr. Sullivan has done today for these hearings that this is simply another attempt to muddy the waters with regard to his position on the matter of abortion, which is a matter that is of grave concern to me and to our constituency.

Although Dr. Sullivan has presented here today many positions, Dr. Sullivan has few convictions when it comes to the fate of the pre-born child.

As a matter of record, more Morehouse Medical School, for example, has been closely associated with abortion-oriented hospitals like Grady Memorial Hospital in Atlanta since 1973. It is also a fact that Dr. Sullivan has never distanced himself from his own endorsements of fetal tissue research, as you just heard, and experimentation. Both practices, which further degrade the child who resides in the womb and must face illegalized death by abortion that not only kills the child but in many cases permanently damages the mother.

Dr. Sullivan has been so equivocal in his opinions and so vague in his contradictory comments that I am one among many who wonders whether or not basic biology has somehow evaded him. Dr. Sullivan will have, if he is confirmed, the opportunity to work his will with regard to the killing of the pre-born child and the use of their tissues and organs for experimental purposes in a manner that should cause everyone among us to be gravely concerned about the fate of these children.

Human persons are never hatched. They are never developed from seedlings. They are never spauned while their parents are swimming up or down a stream. All human persons are created by the union of the human sperm and the human egg through the process of fertilization. This is why someone like Dr. Louis W. Sullivan should not at all be confused about abortion and its aftermath. But he should be clear and difinitive in favor of or against the killing of all innocent children who live in the womb, without exception.

Dr. Sullivan, however, is neither hot nor cold, but he is lukewarm. His lack of convictions and principles should give this committee cause for concern.

Please allow me to point out to you that the American Medical Association has applauded the nomination of Dr. Louis Sullivan. They have been in favor of legalized abortion killing ever since January 22, 1973.

Please allow me to further point out that the Planned Parenthood Federation of America, in a fundraising letter that was just received in thousands of homes just yesterday, applauds Dr. Sullivan but criticizes the Bush Administration for trying to surround him with Pro-Life people.

Please allow me to point out that the Planned Parenthood Federation of America receives millions and millions of dollars of taxpayer funds. Dr. Sullivan will oversee the programs that allow Planned Parenthood to receive these funds. Planned Parenthood is the world's largest promoter of abortion. In fact, over 95,000 abortions every year are done in Planned Parenthood facilities.

Dr. Sullivan, no matter who surrounds him, will make decisions not only about abortion and abortion promoters but about school-based birth control clinics, about chemicals and devices that kill and maime children who live in the womb.

And for these many, many reasons, Mr. Chairman and members of this committee, American Life League find Dr. Sullivan to be totally unacceptable and we urge you not to approve his nomination.

Thank you.

[The prepared statement of Mrs. Judie Brown appears in the appendix.]

The CHAIRMAN. Thank you, Mrs. Brown.

Senator Packwood.

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Armstrong.

Senator ARMSTRONG. Mr. Chairman, thank you very much.

I have only one question for Mrs. Brown. But before I propound it, let me say that I applaud your commitment to the cause of human life. I do not take lightly the statement that you have made and I appreciate it very, very much.

Mrs. BROWN. Thank you, Senator.

Senator ARMSTRONG. But I do want to ask this question. Granted that there has been a great deal of confusion about Dr. Sullivan's position on abortion. In the light of the statements he has made, both publicly and privately, clarifying that, why should we doubt the statement that he himself made this morning in his prepared text to the committee? Is it your view that that statement is simply not to be relied upon or that his position is simply not acceptable as he has stated it himself?

Let me just see if I can find that and read it because I thought he was very, very clear on it. I do not see exactly—here it is.

This is Dr. Sullivan's statement. He says, "I am opposed to abortion except when the life of the mother is threatened or cases of rape or incest. I support a human life amendment embracing the exceptions just noted. Like President Bush, I would welcome a Supreme Court decision overturning *Rowe* v. *Wade.*"

Now, you understand that I am coming from the same concerns that you have expressed. But my question to you is this, do you simply not believe this or is this not an acceptable statement of position to your organization?

Mrs. BROWN. Well, Senator Armstrong, if I might make it perfectly clear, I have read the same press reports that you have. And the fact of the matter is, no, I do not believe the statement he made this morning. He read from a paper with absolutely no inflection or feeling. He subsequently answered pointed questions from you unsatisfactorily as you certainly did point out. And finally, might I point out to you that he has a formal affiliation with the Robert Wood Johnson Foundation, which he has had for many years, a Foundation that spends millions of dollars promoting birth control and abortion among our children ages twelve to seventeen.

Therefore, I have no reason, whatsoever, to believe anything that Dr. Sullivan says about abortion and I am sorry.

Senator ARMSTRONG. I do not know what that Foundation is. Could you tell us what the nature of his connection is with that Foundation?

Mrs. BROWN. Yes. He is associated with the Robert Wood Johnson Foundation, through an association that he has—an investigation of causes of AIDS. In fact, his full resume shows many such Foundations that he is associated with on a consulting basis.

That Foundation happens to be at the forefront of promoting school birth control clinics in schools, not only high schools but middle schools, all across America. They are very committed to abortion and, in fact, require their resources—their high schools and middle schools—to refer for abortion or they will not be allowed to receive funds from Robert Wood Johnson Foundation.

It would seem to me that if Dr. Sullivan, in fact, does concur with the supposed position of the President of the United States, that he would have resigned from any association with the Robert Wood Johnson Foundation many, many years ago.

Senator ARMSTRONG. But was his consulting with this Foundation in some way connected with abortion or was it on other—

Mrs. BROWN. It was connected with all of the public health funding that they do, including school birth control clinics.

Senator ARMSTRONG. I see.

Thank you, Mr. Chairman.

Thank you, Mrs. Brown.

The CHAIRMAN. Thank you.

Mrs. BROWN. Thank you.

The CHAIRMAN. Thank you, Mrs. Brown.

Mrs. BROWN. Thank you, Senator.

The CHAIRMAN. We have had a very good attendance during these hearings and I am prepared to entertain a motion now for the approval of the confirmation by this committee of Dr. Sullivan.

[Whereupon, at 12:45 p.m., the hearing was concluded.]

APPENDIX

ALPHABETICAL LIST AND MATERIAL SUBMITTED

OPENING STATEMENT
THE HONORABLE LLOYD M. BENTSEN
CONFIRMATION HEARING FOR LOUIS W. SULLIVAN, M.D.
FEBRUARY 23, 1989

GOOD MORNING DR. SULLIVAN, AND WELCOME TO THE FIRST OF WHAT I HOPE WILL BE NUMEROUS APPEARANCES BEFORE THE MEMBERS OF THE COMMITTEE ON FINANCE.

I NOTE THAT ON INTRODUCING YOU AS HIS NOMINEE FOR SECRETARY OF HEALTH AND HUMAN SERVICES, PRESIDENT BUSH SAID THAT YOUR MISSION WOULD BE TO "...ATTEMPT TO KEEP HEALTH CARE AFFORDABLE FOR ALL AMERICANS...IMPROVE THE QUALITY AND EFFICIENCY OF HEALTH CARE PROGRAMS...IMPLEMENT THE NEW WELFARE REFORM LAWS...HELP TO CONQUER THE TERRIBLE TRAGEDY OF AIDS...AND CARRY OUT THE CAMPAIGN THEME OF "INVEST IN OUR CHILDREN."

THAT IS A FORMIDABLE AGENDA FOR ANY ADMINISTRATION -- LET ALONE ONE AGENCY WITHIN AN ADMINISTRATION.

I CONFESS THAT I FIND REFRESHING THE PRESIDENT'S WORDS REGARDING ACCESS TO AFFORDABLE HEALTH CARE, IMPLEMENTATION OF A WELFARE REFORM BILL THAT WAS DESIGNED TO EMPHASIZE EDUCATION AND TRAINING, AND HIS EXPRESSED INTENT TO DEVOTE SERIOUS ATTENTION TO INVESTING IN THE FUTURE OF OUR NATION'S CHILDREN.

AS YOU KNOW FROM OUR EARLIER CONVERSATION, MY HOPE IS THAT THIS COMMITTEE WILL SPEND CONSIDERABLE TIME OVER THE NEXT TWO YEARS ON EACH OF THESE ISSUES. IN PARTICULAR, I AM DEEPLY CONCERNED ABOUT THE FINANCIAL CONDITION OF SMALL RURAL HOSPITALS. SINCE THE ADOPTION OF THE PROSPECTIVE PAYMENT SYSTEM FOR MEDICARE, MORE THAN 150 HAVE CLOSED THEIR DOORS -- REDUCING ACCESS TO CARE FOR THOUSANDS OF ELDERLY PERSONS

WHO LIVE IN SMALL TOWNS ALL ACROSS AMERICA. RECENT REPORTS INDICATE THAT ANOTHER 600 HOSPITALS MAY BE IN TROUBLE IF SOMETHING IS NOT DONE TO ARREST THIS TREND.

I AM ALSO VERY INTERESTED IN HEARING ABOUT YOUR PLANS FOR A MORE MEANINGFUL FEDERAL INVESTMENT IN THE FUTURE OF OUR YOUNGEST AMERICANS.

WITH DRAMATIC CHANGES IN FAMILY STRUCTURE OVER THE LAST TWO DECADES, ONE IN FIVE CHILDREN NOW LIVES IN POVERTY; MORE THAN HALF OF ALL AMERICAN YOUNGSTERS WILL SPEND AT LEAST A PORTION OF THEIR YOUNG LIVES LIVING WITH A SINGLE PARENT; ONLY HALF OF THOSE WITH INCOMES BELOW THE FEDERAL POVERTY STANDARD HAVE ACCESS TO HEALTH CARE; AND ALL TOO MANY LEAVE SCHOOL WITHOUT THE SKILLS THEY NEED TO COMPETE SUCCESSFULLY IN AN INCREASINGLY SOPHISTICATED WORKING WORLD. IT IS A NATIONAL TRAGEDY THAT WE HAVE FAILED TO CONTINUE THE PROGRESS OF THE 1960'S AND 1970'S IN DRIVING DOWN THE RATE OF INFANT DEATHS IN THIS COUNTRY -- PARTICULARLY WHEN THE INVESTMENT IN LOW COST PRENATAL CARE PAYS DIVIDENDS OF MORE THAN 3 TO 1 IN THE FIRST YEAR OF A CHILD'S LIFE.

YET THESE ISSUES AND MANY OTHERS ON WHICH I HOPE WE CAN WORK TOGETHER WILL HAVE TO BE ADDRESSED IN THE FACE OF SEVERELY CONSTRAINED RESOURCES. WITH A DEFICIT OF SOME $135B (CBO SAYS $141B, OMB PROJECTS $126B) PROJECTED FOR FISCAL YEAR 1990, WE WILL HAVE TO BE VERY CREATIVE TO MEET OUR OBJECTIVES.

MEMBERS ARE ACUTELY AWARE THAT THE LAST BUDGET SUBMITTED BY PRESIDENT REAGAN CALLED FOR $ 6.5 BILLION IN CUTS TO HEALTH PROGRAMS UNDER THE JURISDICTION OF THIS COMMITTEE, AND LIMITED FUNDING FOR THE EDUCATION PORTION OF THE WELFARE REFORM BILL TO LESS THAN HALF OF WHAT HAD BEEN AGREED TO WHEN THE BILL WAS SIGNED INTO LAW LAST YEAR. PRESIDENT BUSH APPEARS TO AGREE THAT $5.5 BILLION IN MEDICARE CUTS WILL BE NEEDED THIS YEAR.

AS YOU ADDRESS THE COMMITTEE THIS MORNING, I HOPE YOU WILL SPEND A LITTLE TIME OUTLINING IN SOME DETAIL THE PRIORITIES -- BOTH BDUGETARY AND PROGRAMMATIC -- YOU EXPECT TO SET FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES DURING THE COMING YEAR.

DR. SULLIVAN, WE ARE DELIGHTED TO HAVE YOU WITH US THIS MORNING, I LOOK FORWARD TO HEARING YOUR TESTIMONY.

United States
Office of Government Ethics
P.O. Box 14108
Washington, D.C. 20044

February 7, 1989

Honorable LLoyd Bentsen
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Dr. Louis W. Sullivan, who has been nominated by President Bush for the position of Secretary of the Department of Health and Human Services.

The report has been reviewed and advice has been obtained from the Department of Health and Human Services concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter dated February 6, 1989, from the ethics officials of the Department which discusses certain divestitures and recusals, as well as a waiver to be obtained, pursuant to 18 U.S.C. §208 (b), with respect to the Morehouse School of Medicine.

Subject to these commitments and the grant of the waiver, it appears that Dr. Sullivan will be in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

Frank Q. Nebeker /JO

Frank Q. Nebeker
Director

Enclosures

Mrs. Judie Brown, President

American Life League, Inc.

Mr. Chairman, members of the Finance Committee, staff, Dr. Sullivan and audience -

My name is Mrs. Judie Brown. I am President of American Life League, Incorporated. Our national headquarters are located in Stafford, Virginia. American Life League is ten years old and has a membership of 200,000 families across America.

I am here today in order to oppose the nomination of Louis W. Sullivan, M.D., for the position of Secretary of the Department of Health and Human Services.

Recorded in the American Life League summary attached to my statement are the various reports which the print media has made over the course of the past two months with regard to Dr. Sullivan and his many and varied positions on abortion. It is clear that Dr. Sullivan is not only confused about the fate of preborn children, but apparently confused even further by the Supreme Court's devastating decisions of January 22, 1973.

Though Dr. Sullivan speaks loudly today about his concerns about abortion, the record of his previous statements on the subject speaks louder still. It is clear that his posturing for these hearings represents yet another attempt to muddy the waters with regard to his position on these matters.

Please allow me to point out that factual reporting is a profession in which hundreds of honorable men and women are employed. Many among them, as listed in my summary, have

reported Dr. Sullivan's positions, in all of their varied forms. It would appear from the reports which we are familiar with that Dr. Sullivan is in fact a man of many "positions" but few convictions when it comes to the fate of the preborn child.

As a matter of fact, his own medical school, Morehouse, has been closely associated with abortion-oriented hospitals like Grady Memorial since 1973. It is also a fact that Dr. Sullivan has never distanced himself from his own endorsements of fetal tissue research and experimentation - both practices which further degrade the child who resides in the womb and must face a legalized death by abortion that not only kills that child but, in many cases, permanently damages the mother and the extended family as well.

Dr. Sullivan has been so equivocal in his opinions, and so vague in his many contradictory statements, that I am one among many who wonders whether or not basic biological facts with regard to human reproduction have somehow eluded him all these years. Regardless, however, we must each face the fact that if he is confirmed, Dr. Sullivan will preside over a department which presently provides support to organizations that promote, encourage and perform abortions - not only in America, but around the world as well. Dr. Sullivan will have, if he is confirmed, the opportunity to work his will with regard to the killing of the preborn and the use of their tissues and organs for experimental purposes in a manner that should cause each person among us the gravest of concerns.

Human persons are never hatched, they are never developed from seedlings, they are never spawned while their parents

swim up or down a stream. All human persons are created through the union of the male sperm and the female ovum in the biological process known as fertilization. The union of the human sperm and the human egg will always produce a human person, unique in every way. This is why the abortion-killing of a person who lives in the womb is a crime against nature. This is also why someone like Louis W. Sullivan, M.D. should not be at all confused about abortion and its aftermath, but clearly and definitively in favor of the killing or against the killing.

Dr. Sullivan, however, seems to be neither hot nor cold, but lukewarm, at least in some of his statements. This lack of convictions and principles should give this Committee cause for alarm!

Please allow me to point out that the American Medical Association, for example, has applauded the nomination of Dr. Sullivan. This association, of course, is favorable to the killing of the preborn and the experimentation on these children as well.

Please allow me to further point out that a February 1989 letter from Faye Wattleton, President of Planned Parenthood Federation of America, states:

"..In the process, they [pro-life groups] won concessions from the administration that Dr. Sullivan would be surrounded by anti-choice aides hostile to family planning."

The Planned Parenthood Federation of America, the world's leading proponent of abortion on demand performing more than 95,000 killings each year in its own facilities, does not

condemn Dr. Sullivan as an enemy to their cause. Rather Planned Parenthood complains about those who will serve at Sullivan's pleasure, and who will at all times be accountable to him and his positions on abortion, abortifacient birth control methods, school based sex clinics, assisted suicide, euthanasia, and such pharmaceutical nightmares as RU 486 regardless of their personal positions on the matter.

Mr. Chairman, and members of this Committee, I ask you to honestly review the record at hand. Are the ten reporters from the major media outlets I have quoted in my summary all so remiss in their duties that they have all misquoted Dr. Sullivan and his record?

Are the citizens of this nation to be subjected to four years of a Secretary of Health and Human Services who has no regard for the health of the child in utero, or of the pregnant mother who does not wish to kill but who is consistently victimized by a federal mindset that has no time for compassion, buy only for funding those who kill the children?

Mr. Chairman and members of this Committee, please vote against confirmation of Louis W. Sullivan, M.D. for Secretary of Health and Human Services. Our nation's mothers and their preborn children deserve a champion, not an enemy.

American Life League, Inc.

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February 23, 1989

SUMMARY

The Print Media and Louis Sullivan, MD

Quoting the press on Dr. Louis W. Sullivan and his "positions" on abortion, fetal experimentation and other concerns relating to Supreme Court decisions Roe v. Wade/Doe v. Bolton

December 18, 1988, The Atlanta Journal and Constitution, p 3

" Unlike Dr. Sullivan, Mr. Bush favors overturning Roe v. Wade, the 1973 Supreme Court decision that legalized abortion. ... On Saturday, Dr. Sullivan described his position on another controversial abortion-related issue by saying he supports the use of fetal tissue in medical research.

"'We have a number of medical advances that have occurred as a result of research with fetal tissue that have benefited the lives of many people,' he [Sullivan] said."

Kevin Stack, reporter

December 20, 1988, The Washington Times, p A3

"A spokeswoman for Planned Parenthood Federation of America, which provides abortion services, said she was 'delighted' by Dr. Sullivan's published statements..."

George Archibald, reporter

December 21, 1988, Los Angeles Times, p 1,16

"Sullivan reportedly told Hatch and Weber that he stood by his quoted remark on fetal research - 'we have a number of medical advances that have occurred as a result of research with fetal tissue that have benefited the lives of many people.'

"But senior right-to-life leaders have told their associates that top Bush aides, including his son George Bush Jr., had personally pledged to them that the HHS secretary would be someone who shared their position."

David Lauter and Cathleen Decker, reporters

December 21, 1988, New York Times, p. A1, B6

The Times article reports that members of the Bush transition team were satisfied that Sullivan did indeed agree with Bush on abortion and that his previously quoted comments had been taken out of context.

"Dr. Sullivan, who met with Mr. Bush last week, did not answer telephone calls today. On the advice of the Bush

transition officials, Dr. Sullivan's office referred all inquiries to the transition office here [Washington, D.C.]."

Gerald M. Boyd, reporter

December 22, 1988, New York Times, p A1, D22

Dr. John C. Willke, president of the National Right to Life Committee, said in a prepared statement: "...Either Dr. Sullivan has been totally misquoted or he has completely changed his position in the last few days, for he now says that he is pro-life."

In the same Times article, Dr. Sullivan, in a letter to the Atlanta newspapers dated December 18, is reported to have written that he was opposed to abortion except in cases of rape, incest and where the life of the mother is threatened. However the Times notes that Dr. Sullivan did not discuss the remarks attributed to him earlier, nor did he make an effort to correct those quotations.

Robert Toner, reporter

December 23, 1988, New York Times, p A1/26

"Reading from a prepared statement today, Dr. Sullivan said: 'I wish to emphasize that in the areas of abortion, my personal position is that I am opposed to abortion except in the case of rape, incest or threat to the life of the mother. I'm also opposed to federal funding for abortion except in the case of a threat to the life of the mother.

"'This position is the same as that of President-elect Bush...'"

The New York Times reports [12/23/88] that Dr. Sullivan refused to answer numerous questions on the subject of abortion because he suggested that responding to such questions was inappropriate. He also declined to discuss his position on fetal experimentation. He finally refused to comment on the Atlanta newspaper article cited above.

Gerald M. Boyd, reporter

December 23, 1988, Washington Post, Evans and Novak Column entitled "George Bush's Abortion Crisis", p A19

"Suspicions heightened when Reagan enemies lined up to endorse Sullivan: Planned Parenthood, Children's Defense Fund, homosexuals. ..."

Evans and Novak, Columnists

January 16, 1989, The Washington Times, p D3; John Lofton column, "Anxiety About Sullivan"

"...Dr. Sullivan's medical school [Morehouse Medical School], for years, has been affiliated with a hospital [Grady Memorial] that has performed thousands of abortions."

Mr. Lofton reports that Beverly Thomas, director of public relations for Grady Memorial Hospital explained to him that this facility performs an average of 1,200 first trimester abortions every year. He further reports that Ms.

Thomas explained that in 1987 1,397 abortions were performed at Grady Memorial. Further, Grady has performed abortions since 1973 and this would mean that, to date, Grady has performed 18,000 abortions.

Quoting Lofton again: "Dean Roman says Morehouse has no policy regarding abortion. He says he had no idea where Dr. Sullivan stood on abortion prior to his being nominated to be secretary of HHS. And he refuses to say what his own position on abortion is because his faculty and students have multiple positions on this subject, and because 'I don't feel my opinion would add any lucidity to the issue.'"

Finally, Lofton points out that this same medical school, where Dr. Sullivan presides, does not teach students about the humanity of the preborn because everyone has to discern that for themselves!

John Lofton, Columnist

January 15, 1989, Chicago Tribune, p 5

"Sullivan, a longtime friend of Bush's, reportedly told lawmakers on a round of get-acquainted talks on Capitol Hill earlier this month that he supported a woman's right to abortion, though without public funding. He also said his personal view was that the 15-year-old Supreme Court decision legalizing abortion should not be overturned."

"Senator Robert Packwood of Oregon, the ranking Republican on the Senate Finance Committee, and one of the few Republican senators to acknowledge he accepts abortion as a woman's right, said he had met with Sullivan on Jan. 4 and there was 'no misunderstanding' that Sullivan had told him 'his personal view of Roe v. Wade is that it should not be overturned.'"

Janet Cawley and Elaine S. Povich, reporters

January 23, 1989, Medical World News, p 19

"... the AMA dispatched a telegram to the president-elect.

"In part, the telegram read: 'we are concerned about reports that the selection of Dr. [Louis] Sullivan is under reconsideration...Dr. Sullivan's substantive knowledge, experience, and sense of compassion clearly make him eminently qualified for the position. We urge you to proceed expeditiously and we heartily endorse the selection.'"

no attribution

January 26, 1989, New York Times, p D23

"Senator Bob Packwood, the Oregon Republican who reported Dr. Sullivan's position against overturning the ruling [Roe v. Wade] said through a spokesman today that he stood by his original account....

"Now he [Sullivan] appears to have switched his story again perhaps with some prodding by John H. Sununu, the White House chief of staff who met with him twice in the last two days."

The Times went on to report that Sununu tried to explain away the "package" of names recommended to Sullivan as possible appointees to work beneath him, suggestions that would somehow placate pro-life groups.

Steven V. Roberts, reporter

January 26, 1989, Washington Post, p A9

"Health and Human Services Secretary-designate Louis W. Sullivan reversed course again yesterday, unequivocally assuring a group of Republican senators that he favors overturning the Supreme Court's 1973 decision that legalized abortion but failing to end confusion over his beliefs on the divisive issue. ...

"Senators who attended yesterday's meeting with Sullivan in the office of Minority Leader Robert J. Dole (R-KS) said that he had emphatically embraced Bush's view that the 1973 Roe v. Wade decision legalizing abortion should be overturned. That conflicts with earlier statements by Senator Bob Packwood (R-OR) that Sullivan had told him he personally opposes overturning the high court ruling."

Tom Kenworthy and Ann Devroy, reporters

January 27, 1989, Washington Post, Carl Rowan column entitled "Prescription for Dr. Sullivan", p A21

Carl Rowan, not noted as a friend to pro-life concerns, notes: "I think that Sullivan can make a mark on this town, the media and America if he shows up at his confirmation hearings revealing no signs of the 'mealy-mouth syndrome', weak knees or cold feet."

Carl Rowan, Columnist

February 1, 1989, New York Times, p A14

"Dr. Sullivan spent three hours Saturday practicing for his hearings, as White House advisers fired questions at him.

"... Alarmed at the deteriorating situation, the Administration has now called in professional political consultants to advise Dr. Sullivan. White House officials also are protecting him from press inquiries..."

Steven V. Roberts, reporter

February 2, 1989, New York Times, p B5

"The official line is that the Federal Bureau of Investigation has not completed its background check, but lawmakers from both parties say that Dr. Sullivan needs more

time to prepare for the hearings. The nominee himself, who has declined all requests for an interview, is reported confused and upset about the turn of events....

"'He's [Sullivan] been wounded, at least temporarily, but not necessarily in the long run,' said one White House adviser. `He's created a feeling that he's naive, and his credibility has been hurt a little bit. If he gets through the hearings well, and appears to take hold of his job, he`ll be fine. But he's probably used up some of his room for error.'"

Steven V. Roberts, reporter

February 3, 1989, Washington Times, p F3; John Lofton column entitled "Putting Ethics to the Sullivan Test"

"Mr. Bush declared: 'The guiding principle will be simply to know right from wrong, to act in accordance with what is right and to avoid even the appearance of what is wrong.'...

"But if Mr. Bush is so concerned about ethics, and even the appearance of unethical conduct - and I think he's sincere about this - then why has he stood behind Dr. Sullivan '100 percent' when Dr. Sullivan's positions on abortion have been anything but ethical?"

John Lofton, Columnist

February 5, 1989, New York Times, p. 26

"To propitiate Mr. Packwood, Dr. Sullivan has worked out a statement in which he will take the blame for the incident. The senior official quoted Dr. Sullivan as saying, 'I'm stating that I misspoke, that I caused the confusion.'"

Steven V. Roberts, reporter

end

Copies of all print media copy from which the above excerpts were taken are available: American Life League, Inc., PO Box 1350, Stafford, VA 22554, 703-659-4171

CONFIRMATION HEARING OF DR. LOUIS SULLIVAN
SENATOR BOB DOLE
THURSDAY, FEBRUARY 23, 1989

Mr. Chairman, I am grateful for this opportunity to say a few words about the man who will be America's next Secretary of Health and Human Services.

I have come to know Louis Sullivan -- and I have studied his record -- and there is no doubt in my mind that he is more than qualified to take on the tough challenges that await him here in Washington.

He is a man of deep experience and commitment who has dedicated his career to excellence -- not only in teaching, but in administration, in research and in outreach to every segment of society longing for decent health care.

Mr. Chairman, President Bush has made a quality pick for the Department of Health and Human Services.

George Bush has made it clear that his Administration is determined to build new bridges to America's minorities -- I can think of no better way than to start right at the top, in the President's own Cabinet.

I commend President Bush for this important signal to America.

It's not only "kindler and gentler", its the right thing to do.

I know all about the mini-flap over Dr. Sullivan's alleged views on abortion, I recall all the media hype and the instant criticism. But to get the straight scoop, I invited Dr. Sullivan to my office to clear the air along with several of my colleagues.

He assured us that he shares the President's stance on abortion, and beyond that fact, his bottomline answer said it all: The President makes policy, and the Cabinet implements it.

Mr. Chairman, there are huge problems facing America today: AIDS, the skyrocketing cost of medical care; the steadily disappearing rural hospitals; an unacceptable level of infant mortality; the need for long-term care; the need to break the welfare cycle; the need to reassure our elderly of our support; and the continuing need to break down physical and attitudinal barriers that keep America's disabled out of the mainstream.

No doubt about it, the critical list is overloaded.

My prescription is this: a speedy Committee and Senate confirmation of Dr. Louis Sullivan.

There's plenty of work to do. We need to get started.

Statement by Senator Dave Durenberger
Louis Sullivan Appointment
February 1, 1989

I am honored to welcome Dr. Sullivan here today, and commend President Bush for presenting us with such a distinguished candidate for Secretary of Health and Human Services.

The Department of Health and Human Services faces some of the most significant challenges of our society and holds the promise of creating for all Americans a better, more fulfilling life. It is within this Department that the tough choices and decisions will be made that can truly make this nation kinder and gentler. These will not be easy decisions, and I am pleased that we have before us a candidate with the knowledge, experience and expertise to help find new ways to meet these challenges while faced with the budgetary constraints of our times.

We undeniably have some of the best health care institutions in the world and our nurses and physicians are among the best trained. Yesterdays miracles are today becoming commonplace. Millions of Americans enjoy levels of health care previously unheard of. Yet many others are not sharing equally in these benefits and there is evidence that budget constraints are in fact eroding services to the most needy; the poor and elderly.

Given the challenges ahead, I am pleased that President Bush has chosen someone with such a long and distinguished career in the Medical profession, and with the knowledge and sensitivity to these issues as Dr. Sullivan has. I look forward to hearing from him about the future of the health care industry in this country and the role he will be playing as Secretary of the Department of Health and Human Services.

I am particularly interested in the role health promotion and disease prevention can play in improving the quality of life while conserving health care resources. I am pleased to note that Dr. Sullivan shares this interest particularly in the area of nutrition. I am also pleased that we share a concern for those who do not have access to health services; the uninsured and those living in rural and inner city areas. Moreover, as an advocate of Health Maintenance Organizations, I note with interest Dr. Sullivan's work with the Kaiser Permanente HMO in Atlanta.

While I particularly look forward to working with Dr. Sullivan on upcoming health care issues facing this country, I also hope we will have the opportunity today to hear from Dr. Sullivan on some of the other very serious issues facing this country. As the deficit continues to grow, we are increasingly burdening future generations with the liabilities of today. Already children make up the poorest segment of our society. If this nation is to continue to maintain the today's standard of living, the priorities we set must reflect not only the priorities of today, but also the priorities of tomorrow.

We must find new ways to ensure prosperity for today and tomorrow. Over the years I have come to realize that the way a great society measures the quality of that society's commitment to its individuals is not by the amount of money we spend but by the amount of opportunity we provide every member of this society. I am pleased with the progress we made in this area last year when this committee lead by Senators Bentsen and Moynihan made significant reforms in catastrophic care and welfare reform.

While these are significant steps forward in these areas, we still have much work to do in areas such as child care, disability and care for the frail elderly. I look forward to working with you to ensure hope and opportunities to all Americans today and in the future.

Again, Dr. Sullivan, I am impressed by the expertise and insight you bring to this office, and commend President Bush on his choice for Secretary of Health and Human Services. I look forward to your testimony.

OPENING STATEMENT OF SENATOR JOHN HEINZ
CONFIRMATION HEARING FOR DHHS SECRETARY DESIGNATE LOUIS SULLIVAN

2/23/89

Mr. Chairman, I wish to join my Colleagues in welcoming Dr. Sullivan's appearance before this Committee. I also want to recognizing the substantial financial sacrifice Dr. Sullivan is prepared to make in taking the helm of the Department of Health and Human Services and leaving his position at Morehouse. This is an unfortunate, but noble statement of one man's commitment to public service. I believe it is also a reflection of the personal commitment and professional dedication that Dr. Sullivan, like his predecessor, would bring to the Department.

As I listen to Dr. Sullivan's statement and his responses to the Committee's questions this morning, what I will be holding in my mind is the millions of persons -- young and old alike -- who are directly affected by the programs that would fall under his stewardship. I will also be thinking of the difficult task Dr. Sullivan would face as Secretary in protecting essential programs such as Medicare, Medicaid, community service programs, and health professions education programs -- programs which the President is proposing be significantly cut.

Mr. Chairman, we face significant budgetary and programmatic challenges in this next year and in the years ahead that will require creative and cooperative solutions. As a clinician, educator and administrator, Dr. Sullivan brings a wealth of expertise to the Administration and, today, to this Committee. I therefore look forward to learning of Dr. Sullivan's near and long-term vision for the Department and to working together to bring his and our nation's priorities to fruition.

STATEMENT BY THE HON. BEN JONES

GEORGIA SCHOOL BOARDS ASSOCIATION
FEDERAL EDUCATION CONCERNS
101st CONGRESS

I. Federal Funding

Federal education funding is a perennial issue. The new Congress and the Administration will have an opportunity in 1989 to make education truly a national priority. GSBA and the National School Boards Association believe that the federal budget must begin to show a clear priority for educating the at-risk youth of our nation. Further, there is strong sentiment for the federal budget to support the enhancement and quality of teaching in all schools. It is essential for an increase in major federal education programs of ten percent (10%) over inflation in FY90 or $1.4 billion. New funding should include increases for: (1) all programs; (2) Chapter I basic and concentration grant funds; (3) school-aged handicapped; (4) basic skills/dropout prevention and Even Start programs; and (5) new teacher incentive programs.

II. Labor Issues

The 101st Congress will probably consider many pieces of labor legislation that would impact not only the private sector but public education as well. Some of these proposals, most notably the Parental and Medical Leave Act and the Minimum Health Benefits for All Workers, would fund employee benefits through mandates upon employers. Other proposals, such as those in the area of child care, are likely to be offered not as mandates but as costs to be borne by the federal government through grants-in-aid or tax breaks. GSBA opposes measures such as these which will impose a greater burden on the school system governance structure and taxpapers.

III. Child Care

Child care presents a different set of options for local school systems. While Senator Kennedy's Smart Start bill emphasizes education, there are other proposals which are designed to provide financial relief to parents. Further, some proposals will address concerns about the reliability and quality of care. You can readily see that the involvement of school systems will require adjustments in available facilities, personnel, and funding. Great care should be given to mandating programs in the child care area, because it involves advocacy groups, organized labor and a major segment comprised of religious institutions, private facilities, and home providers - each with different and, at times, competing interests. Estimated costs for this industry are $2-3 billion and could escalate many times because of its size.

IV. At-Risk Youth and Dropouts

The reauthorization of the Carl D. Perkins Vocational Education Act, the Child Nutrition Program, including the school lunch and breakfast programs, and portions of the Education for All Handicapped Children Act, P.L. 94-142, are critical to addressing the At-Risk Students in our schools. Consideration must also be given to fully funding federal education programs such as Chapter I to cope with the growing numbers of underprivileged youth and potential dropouts in our schools. It is imperative that increased funding be provided to cope with the need to improve the thinking skills of our future workforce and leadership.

Statement by Senator George J. Mitchell

Finance Committee Hearing

Confirmation of Dr. Louis W. Sullivan

Secretary of the Department of Health and Human Services

February 23, 1989

Good Morning. I want to join my colleagues on the Finance Committee in welcoming Dr. Louis Sullivan here this morning. Dr. Sullivan, you have been nominated for one of the most difficult jobs in Washington - running the Department of Health and Human Services.

As a member of this Committee, and as the former Chairman of the Health Subcommittee, I am painfully aware of the tremendous challenge we face in providing health and human services to the most deserving of our citizens in a time of severe fiscal constraints upon the federal budget.

The citizens most dependent upon the programs within the jurisdiction of your department are often the most frail in our society - children, the elderly and the disabled. As our population ages we face an enormous burden of assuring the soundness of the Social Security System, the fiscal solvency of the Medicare Program, and the safety net of Medicaid coverage for poor elderly.

At the same time we are aware of the serious problems facing children in America today. As our colleage Senator Moynihan often reminds us, one in five American children lives in poverty. Often these children do not have access to basic

health care services. We must find viable ways to invest in the health and welfare of the nation's children or we will pay a tremendous price for our failure to do so - both in fiscal costs and in human costs.

I commend you for your willingness to take on this great task and pledge my support to work with you to protect the important programs of the Department of Health and Human Services. We will be called upon to make difficult choices. We may have disagreements about those choices. But we must keep in mind that we share a common goal - to provide access to health care and other critical human services for all of our citizens.

Question: Dr. Sullivan, I'd like to raise my concerns about the Low-Income Energy Assistance Program or LIHEAP. This program is administered by HHS and provides assistance for low-income households to meet their home heating or cooling expenses.

During the 1980's LIHEAP has been cut like very few other domestic programs. Only looking at the past 3 years, LIHEAP spending has been cut about 24 percent, dropping from $1.822 billion in FY87 to $1.532 billion in FY88 to $1.383 billion in the present fiscal year.

President Reagan proposed addition reductions in LIHEAP to $1.1 billion for FY90. It's not certain from President Bush's budget proposal that LIHEAP is to be spared from further cuts in FY90.

What is your view on the value of LIHEAP and the impact of the program on its potential beneficiaries?

I hope you will closely look at this program and determine that it deserves to be maintained at an adequate funding level for FY90.

LONG TERM CARE

I believe that the lack of a comprehensive long term care program is one of the most serious gaps in our health care system. As you know, I have been involved with the development of a comprehensive Long Term Care bill and am committed to the coordination and financing of long term care services for Medicare beneficiaries.

My legislation attempts to achieve a balance between a significant role for private insurance with the establishment of a major federal program.

What is your view of the role of the federal government in the development of a comprehensive long term care program for Medicare beneficiaries?

MEDICAID BUDGET

While the FY'90 Bush Budget rejected the proposal included in the Reagan Budget to reduce Medicaid funding to States by $1.1 billion, it does include a proposal to reduce the matching rate for administrative costs of certain Medicaid programs. In light of the Medicaid expansions contained in OBRA'87 and the Catastrophic bill which were passed by Congress and signed by President Reagan, it it difficult to understand how States would be able to meet the new expansions while having their federal Medicaid funding reduced.

Are you aware of such a proposal to reduce Medicaid funding in the Bush Budget, and if so would you support such a reduction ?

UNINSURED

One of the most serious issues in health policy facing our nation today are the 37 million Americans with no health insurance. During President Bush's campaign he discussed this issue and indicated support for a Medicaid buy-in to resolve the problem. While expanding Medicaid could provide health care to many poor people, particularly pregnant women and children, I do not believe it is the most cost-effective way to reach those persons who are employed but have no health insurance.

Do you believe that private employers have a responsibility to provide health insurance for their employees ?

Would you support some kind of incentive program, either through mandates or tax incentives and disincentives, to encourage employers to take responsibility for providing health care to their employees and their dependents ?

Statement by

Senator Daniel Patrick Moynihan

Mr. Chairman:

I join my colleagues in welcoming Dr. Sullivan in his first appearance before this Committee.

I will be particularly interested in his thoughts on how the Department of Health and Human Services is preparing to implement the welfare legislation which Congress enacted last year, after two decades of debate and deliberation.

On January 23, I wrote President Bush on this matter. I have since received a most polite note from Mr. Frederick D. McClure, Assistant to the President for Legislative Affairs informing me that the letter has been sent to "the President's policy advisors." Not, that is, to the President. However, Mr. McClure has kindly consented to my making public the portion of the letter referring to welfare.

> In the closing weeks of the last Congress we passed two massively important bills. The Family Support Act at long last redefined and redirected our welfare program. The Anti-Drug Abuse Act established an unprecedented federal policy of providing "treatment on request" for drug users.
>
> The problem is that the government whose leadership you now assume does not have the institutional capacity to carry out either measure.
>
> For reasons not wholly clear to me, the Deparment of Health and Human Services has almost altogether withdrawn from the field of welfare. Even the word was dropped from its title in 1980. This is odd when you consider that perhaps one child in three is supported by this Federal program at some point in their youth. But there you are. There is nobody in HHS who knows anything about the subject or about the new legislation. If you are to succeed here, you will have to create a new institution, much as in the past Presidents created the Bureau of Reclamation, the FBI, the National Institutes of Health, and such like. Governors can help you, notably Castle and Kean, and of course your Chief of Staff.
>
> * * *
>
> Finally, may I note that those of us involved with the two bills quite understood all this. You

have a right to our support, should you decide to be open about the matter.

As to this matter of institutional capacity, scholars have long recognized that public policies are only as good as the institutions that run them. In a January 6, 1989, New York Times article, Professor Richard Nathan writes that,

> The key to public policy is institutional change...real and deep changes in the way institutions work that can help us save some of the people trapped (or in danger of being trapped) in the underclass system.

There is that. And there is also emerging in our land a dual family system. Or so I believe. Here in this Committee, we have been discussing this matter for some time. Just last week the Census Bureau, alert as always, provided us with further information. A press statement accompanying their "Marital Status and Living Arrangements: March 1988," stated:

> The proportions of Black, White, and Hispanic children living with one parent increased significantly from 1980 to 1988, according to a report from the Commerce Department's Census Bureau.
>
> The percent of Black children under age 18 living with one parent rose from 46 percent in 1980 to 54 percent in 1988. The proportion for White children increased from 15 percent to 19 percent, and the Hispanic proportion rose from 21 percent to 30 percent.

-30-

STATEMENT OF SENATOR SAM NUNN

INTRODUCTORY REMARKS

CONFIRMATION HEARINGS OF DR. LOUIS SULLIVAN

Mr. Chairman, members of the Committee, I am delighted to be here today to introduce Dr. Louis Sullivan. I am pleased that the nation can now benefit, as Georgia has, from this articulate, compassionate health care advocate.

Dr. Sullivan left a successful career in Boston in 1975 to return to his alma mater as dean and director of Morehouse College's Medical Education Program. Under his leadership, in a period of 3 years, Morehouse went from a two-year medical education program to a prestigious four-year institution. Its mission is to produce physicians who devote their lives to the primary care needs of the uninsured and the underserved.

Of the students who have graduated from Morehouse School of Medicine approximately 75% have gone into primary care residencies. They serve from the northeast to the west coast in the OB-GYN, pediatrics, internal medicine and family practice fields.

The next Secretary of Health and Human Services has the difficult task of establishing our national priorities and allocating scarce federal resources in the areas of health care and social services. As a health care professional, Dr. Sullivan will bring to that important post a thorough knowledge of the health care problems our nation faces including AIDS, infant mortality, heart disease, cancer and drug abuse. If Dr. Sullivan's track record is any indication of his ability, I am

confident that he will be an effective advocate for the most pressing health and social service needs of our country.

One of the most disturbing concerns in the medical arena is the health problems of the uninsured and medically underserved. It has been estimated that there are 37 million uninsured in our country today. Of Georgia's 6 million citizens, approximately 15% (904,000) are uninsured. Sixty-six counties in Georgia are designated as Health Manpower Shortage Areas. This means that 18.5% of Georgians live in underserved areas. In addition, of our 159 counties, 69 do not have an obstetrician. In Georgia and at Morehouse School of Medicine, Dr. Sullivan has been actively involved in these issues and he will be able to draw on this experience as he develops responsible policies to address the needs of the uninsured and underserved in our entire nation.

Containing costs, particularly in the Medicare program, will dominate the health care agenda. As an administrator, Dr. Sullivan is aware of the importance of sound fiscal policies and, I believe, is prepared to work with Congress to find workable solutions to slowing the growth of this program.

The nominee and I have discussed the implications of drugs in our society and the increased emphasis which must be placed on reducing the demand for drugs through effective treatment and education programs.

Dr. Sullivan's compassion, his experience, and his competence will serve him and the country well as he embarks on a new endeavor. I do not envy the challenges he will face during the next several years; however, I am confident that he will approach these challenges with the same vigor that is characteristic of his efforts in the past. I highly recommend Dr. Louis Sullivan to you as Secretary of the Department of Health and Human Services.

STATEMENT OF LOUIS W. SULLIVAN, M.D.

CONFIRMATION HEARINGS

SENATE FINANCE COMMITTEE

FEBRUARY 23, 1989

Mr. Chairman, Members of the Committee, I am honored to appear before you today. I am honored, first, to enjoy the confidence and trust of our new President, as reflected in his nomination of me for the Office of Secretary of Health and Human Services. I admire George Bush; I am, frankly, proud to claim his friendship; and, if confirmed, I shall carry out the task he has given me in such a way that the hopes and aspirations we mutually hold for this Department, and for the American people, are fulfilled.

I am privileged to have the opportunity to discuss with this distinguished Committee the broad contours of those hopes and aspirations. They center on the President's commitment -- a commitment I fully share -- to the ideal of a "kinder, gentler" America. No Department will be more directly affected by that commitment than HHS, which touches the lives of Americans wherever they are most vulnerable -- from the beginning of life, through health and sickness, from the foods we eat to the medicines we take, to the care of the elderly and disabled.

Taking that commitment as my guide, I intend to see to it that the regulations we promulgate at HHS carry a firm, but gentle touch; that HHS employees take pride once more in the invaluable service they render our citizens; that government itself comes to have a more human face.

This may seem to be an unreasonably idealistic goal. But in our lifetime, many idealistic goals have in fact become reality. Our economic system has brought well-being to numbers undreamed of in human history. Our once-segregated society, where the color of one's skin determined where one ate, went to school, and lived, is evolving into a nation of mutual

understanding and good will. This has been especially so in my native South, which has achieved remarkable progress in racial harmony over the past 2-3 decades. A tolerant, compassionate society is no longer merely an idealistic goal; it is within our reach.

I have seen these momentous changes in my own life. When I entered medical school in 1954 -- the year the Supreme Court struck down segregation in public schools -- there were very few black doctors, and it seemed naive to suppose that the medical profession could ever be completely open to all races. But today, my oldest son is a doctor, and the young Morehouse School of Medicine is sending scores of highly trained, deeply committed young minority men and women into medically-underserved rural areas and inner cities of our country.

Bringing a new spirit of kindness and compassion to a vast federal Department -- one with 114,000 employees and a $400 billion budget -- may seem excessively idealistic. But it is an ideal we can and must attain. Nothing less shall be my goals, as Secretary of HHS.

As a physician and as one who came from a proud family of modest circumstances, I have a special grasp of the responsibilities of HHS. During my medical career, I have seen remarkable progress in the nation's system of health care, with programs like Medicare and Medicaid making available to the elde and poor, services that were once open only to the rich. As an academician, I have rejoiced in the great strides we have made against cancer, polio and other dread diseases, through research supported by the National Institutes of Health. And I have seen the improvements brought to the lives of millions of our children and less privileged through HHS' program of human services.

But much remains to be done. And it must be done with an eye to reducing the Federal budget deficit -- a concern, I know, of paramount importance to this Committee, as you consider not

only how funds are spent, how they are to be raised, as well.

Let me indicate how we might begin to make further progress toward improving the health and well-being of our citizens, bearing these constraints in mind:

o First, we must assure the solvency of programs like Social Security and Medicare. We must find ways to contain escalating medical costs, without sacrificing our commitment to quality health care for all. And we must emphasize health promotion and preventive medicine strategies, because promoting health is ultimately more humane and economical than merely treating illness.

o Second, we must sustain and improve programs like Aid to Families with Dependent children and Head Start -- programs that help the poor learn and work their way out of poverty. Implementation of last year's welfare reform legislation will therefore be one of my highest and earliest priorities.

o Third, we must seek ways to strengthen family life and reinforce our society's sense of community, our shared sense of responsibility and commitment to one another. As President Bush notes, "family . . . is a powerful word, full of emotional resonance," and those of us who have been blessed with strong families must work to bring that blessing to those who have not.

Attention to family means that the health of our children must be our particular concern, for nothing less than our nation's future is at stake. Today, that future is threatened by the epidemic of drug abuse among our young. I am deeply committed to the battle against "this scourge," as President Bush has called it, and will work long and hard with this Committee, with the President, and with his Drug Advisor, Mr. Bennett, in pursuit of victory.

o Fourth, we must sustain our biomedical research efforts in the quest for a cure for AIDS. As the President has said, "We must commit the resources and the will to find a cure.

American science must know that we have the resolve to beat this disease." At the same time, however, we must not slight our efforts to conquer cancer, heart disease, diabetes and other disorders afflicting our citizens.

o Finally, we must focus our limited resources on the poor, the disadvantaged, and the neglected in our society. Programs like Medicare and Medicaid must be carefully administered so that rural and inner city health care needs are met, and the nation's poor are accorded decent, dignified care.

During my career as a doctor, scientist, teacher, and administrator, I have developed the habit of consultation -- of seeking the wisdom and experience of others, exploring many alternatives, sometimes even playing the devil's advocate in order to understand all sides of an issue. As my wife and children will attest, this is very much a part of my nature.

Such free and robust discussion was an essential part of doing an effective job, as President of Morehouse School of Medicine. As nominee for Secretary of HHS, however, it has made for a good deal of press. With apologies to Senator Packwood for having misspoken when I met him, thereby causing confusion, please allow me to clarify some important matters.

I am opposed to abortion, except when the life of the mother is threatened, or cases of rape or incest.

I support a human life amendment, embracing the exceptions just noted.

Like President Bush, I would welcome a Supreme Court decision overturning Roe v. Wade.

If confirmed, I will actively encourage adoption and other alternatives to abortion.

I hope this clarifies my position on the very difficult issue of abortion.

When the President nominated me for this position, he presented me a major challenge. If confirmed by the Senate, I

will need and will seek your advice and counsel in meeting that challenge. I intend to approach it in the spirit of a charge I gave to the first graduating class of the Morehouse School of Medicine in 1985. I challenged those young graduates to:

> Continue to grow -- in knowledge, wisdom, excellence and service -- for the rest of their lives, in their quest to be the complete physician. That physician is a scientist, a counselor, an educator, an humanitarian, a leader, and a friend -- to his patients and to his community. He is never satisfied with his level of professional attainment, but is forever striving to reach a higher ground -- to master the new biology, to comprehend more fully our expanding technology, to increase his understanding of the social, philosophical and ethical dilemmas which confront us now . . . and will confront our society for many years to come. This is an awesome, and welcome challenge.

The challenge I issued those young doctors is mine, as well. With the support of my wife, Ginger, and my three children, Paul, Shanta, and Halsted, with the continued confidence of our President, and with your concurrence, I intend to meet that challenge, in service to the people of the United States.

CURRICULUM VITAE

LOUIS W. SULLIVAN, M.D

DATE OF BIRTH: November 3, 1933
Atlanta, Georgia

MARITAL STATUS: Married, three children

EDUCATION

High School: Booker T. Washington, Diploma
Class Salutatorian, 1950

College: Morehouse College, B.S.
Magna cum laude, 1954

Medical School: Boston University, M.D.
Cum laude, 1958

ACADEMIC AND PROFESSIONAL POSITIONS

Medical Student Fellow of the National Foundation--Summer, 1956
Internship: New York Hospital--Cornell Medical Center, 1958-59
Medical Residency: New York Hospital, Cornell Medical Center, 1959-60
General Pathology Residency: Massachusetts General Hospital, 1960-61
Opportunity Fellow: John Hay Whitney Foundation, 1960-61 Research Fellow in Medicine (Hematology): Thorndike Memorial Laboratory (Harvard Medical Unit), Boston City Hospital and Harvard Medical School, 1961-63
Instructor in Medicine: Harvard Medical School, 1963-64
Research Associate: Thorndike Memorial Laboratory, Boston City Hospital, 1963-64
Assistant Professor of Medicine: New Jersey College of Medicine, 1964-66
U.S. Public Health Service Research Career Development Awardee, (NIH), 1965-66, 1967-71
Assistant Attending Physician: Medical Center, Jersey City, NJ, 1964-65
Associate Attending Physician: Medical Center, Jersey City, NJ, 1965-66
Co-Director of Hematology: Boston University Medical Center, 1966-75
Assistant Professor of Medicine: Boston University School of Medicine, 1966-68
Assistant Visiting Physician: University Hospital and the Fifth and Sixth (Boston University) Medical Services, Boston City Hospital, 1966-68
Associate Professor of Medicine: Boston University School of Medicine, 1968-74
Associate Professor of Physiology: Boston University School of Medicine, 1970-74
Associate Visiting Physician: University Hospital and the Fifth and Six (Boston University) Medical Services, Boston City Hospital, 1968-74
Co-Project Director, Boston Sickle Cell Center: Trustees of Health and Hospitals, 1972-73
Project Director, Boston Sickle Cell Center: Trustees of Health and Hospitals, 1973-75
Director of Hematology: Boston City Hospitals, 1973-75
Professor of Medicine and Physiology: Boston University School of Medicine, 1974-75
Professor of Nutrition: Boston University School of Dentistry, 1974-75
Visiting Physician: Boston City Hospital, 1974-75
Visiting Physician: University Hospital, 1974-75
Professor of Biology and Medicine: Morehouse College, 1975-81
Professor of Medicine, the Morehouse School of Medicine, 1981-
Dean and Director, School of Medicine at Morehouse College, 1975-81
President and Dean, The Morehouse School of Medicine, 1981-85
President, The Morehouse School of Medicine, 1985-

MEDICAL AND SCIENTIFIC SOCIETIES

Begg Honor Medical Society, 1956
Alpha Omega Alpha Honor Medical Society, 1957
American Federation for Clinical Research, 1961-
American Society of Hematology, 1963-
Society for the Study of Blood (New York), 1964-66
Secretary/Treasurer, 1965-66
Society for Experimental Biology and Medicine, 1965-
Certified in Internal Medicine by American Board of Internal Medicine, 1966
Certified in Hematology by American Board of Internal Medicine, 1972
American Physiological Society, 1962-
Boston Blood Club, 1967-75
Secretary, 1968-69; Chairman, 1969-70
American Society for Clinical Investigation, 1967-
Phi Beta Kappa, (Elected as alumni member), 1975
Institute of Medicine, National Academy of Sciences, 1975
American Medical Association, 1975-
National Medical Association, 1975-
Atlanta Medical Association, 1975-
Medical Association of Atlanta, 1975-
Medical Association of Georgia (MAG), 1975-
Georgia State Medical Association, 1975-
Legislative Liaison Committee (MAG), 1982-83
Search Committee for Executive Director Medical Association of Georgia, 1983-84
Education Committee (MAG), 1978-82
Founding President, Association of Minority Health Professions Schools, 1978-83
Fellow, American College of Physicians, 1981-
Member, Health Care Financing Subcommittee, American College of Physicians, 1988-
President, Foundation for Minority Health Professions, 1983-85 Association of Academic Minority Physicians, 1985-
Member, Board of Directors, Caduceus Foundation, 1986-
Member, Board of Scientific Counselors, Agency for Toxic Substance and Disease Registry, 1988-89

ADVISORY AND CONSULTING POSITIONS

Medical Advisory Board, National Leukemia Association, 1968-70
(Chairman, 1970)
Special Consultant, General Clinical Research Center Committee, Division of Research Facilities and Resources, National Institutes of Health, 1969-73
Associate Editor, Nutrition Report International, 1969-73
Editorial Board, American Journal of Hematology, 1975-77
Member of Training committee, American Society of Hematology, 1969-71
Consultant Physician, Veterans Administration Hospital, Boston, 1969-71
Consultant Physician, Framingham Union Hospital, 1970-75
Sickle Cell Anemia Advisory Committee, National Institutes of Health, 1971-73
Blood Diseases and Blood Resources Advisory Committee, National Heart and Lung Institute, 1974-75
Chairman of the Board, University Comprehensive Health Program, 1975-77
Editorial Board, Journal of Medical Education, 1977-78
Member, National Advisory Council, Division of Research Resources, National Institutes of Health, 1977-79
Member, National Board of Medical Examiners, 1977-80
Member, Board of Directors of National Fund for Medical Education, Educational Advisory Committee, 1977-80
Member, Task Force on Minority Opportunities in Medicine, Association of American Medical Colleges, 1976-78
Member, Task Force on the Support of Medical Education, Association of American Medical Colleges, 1977-80
Member, Advisory Committee to the Director, National Institutes of Health, 1980-82
Member, Career Development Committee, Veterans Administration Medical Research Services, 1980-1984

Member, Blood Products Advisory Committee, Food and Drug Administration, 1981-1985
Member, Visiting Committee, Harvard Medical and Dental Schools, 1983-88
Member, Board of Visitors, School of Medicine, University of California at Davis, 1983-
Member, Commission on Health and Human Services, Southern Regional Education Board, 1985-87
Vice Chairman, Commission on Health and Human Services, Southern Region Education Board, 1985-87
Member, Board of Directors, Friends of the National Library of Medicine, 1985-
Member, Executive Board, Boy Scouts of America, 1986-
Atlanta Council Representative to the National Council, Boy Scouts of America, 1988-
National Cancer Advisory Board, National Cancer Institute (NIH), 1986-92
Member, Board of Trustees, Woodruff Arts Center, 1986-
Member, Advisory Committee to the Harvard-MIT Division of Health Science and Technology, 1987-
Member, the Robert Wood Johnson Health Policy Fellowship Board, Institute of Medicine, National Academy of Sciences, 1988-1991

MEDICAL SCHOOL TEACHING AND ADMINISTRATIVE ACTIVITIES

Boston University
Coordinator of Hematology Section, Biology of Health, 1971-75
Coordinator of Hematology Section, Biology of Disease, 1966-64
Chairman, Third Year Teaching Committee of the Department of Medicine, 1964-74
Chairman, Third Year Promotions Committee, 1972-74
Member, Curriculum Committee, 1969-74
Chairman, Search Committee for the Chairman, Department of Obstetrics and Gynecology, 1974

RESEARCH ACTIVITIES

Studies of nutritional anemias (vitamin B12 and folate deficiences)
Studies of minimal daily requirements of vitamin B12 and folic acid and factors influencing their requirements
Effects of alcohol and other agents on hemopoiesis
Studies of the metabolic interrelations of vitamins B12 and folate
Humoral factors affecting platelet production

CIVIC ORGANIZATIONS

Atlanta Rotary Club, 1977-
Member of Board, Georgia Division, American Cancer Society, 1976-82
Member of Board, Atlanta Division, American Red Cross, 1976-82
Member of Board, Atlanta Division, American Lung Society, 1976-82

AWARDS

Honoree of the Year for Outstanding Contributors to Education in Georgia from the State Committee on the Life and Health of Black Georgians, 1983
Southern Christian Leadership Conference, Drum Major Award for Service to Education, 1982
Endowed Visiting Professorship in Pharmacology, in the name of Louis W. Sullivan, M.D., established by the Sterling Drug Company, 1980
Outstanding Alumnus Award, New York Hospital-Cornell Medical Center Affiliated Alumni Association, May 11, 1984
Honoree, National Association of Minority Medical Educators, for outstanding contributions to the education of minorities in medicine, September 22, 1984
1985 Alumni Award for Distinguished Public Service, Boston University, October 19, 1985
The Equitable Black Achievement Award in Education, 1986
Distinguished Community Service Award, the Atlanta Urban League, November 19, 1987

Senator Bentsen

Question

While President Bush's budget proposes to expand Medicaid coverage to pregnant women and infants with incomes up to 130% of poverty, many uninsured persons, particularly children, live in families with incomes above this level. What can be done to address this problem?

Answer

Two of my top priorities as Secretary of the Department of Health and Human Services are to improve health care for the poor and to provide health insurance for the 37 million uninsured in this country. As a physician and father, I am particularly concerned that our children receive the health care they need to live full and productive lives.

President Bush's budget begins to address these goals by:

- Mandating Medicaid coverage of pregnant women and infants with incomes up to 130% of the poverty level,
- Requiring Medicaid coverage of childhood immunizations for those receiving Food Stamps, and
- Requiring States to conduct outreach and public education programs on the need for and availability of prenatal care in areas with high rates of adverse pregnancy outcomes.

Many groups, such as the National Association of Children's Hospitals and Related Institutions, the American Medical Association and the National Leadership Commission on Health Care have provided us with reports containing thoughtful recommendations for addressing the unmet health care needs of children, as well as other uninsured individuals. We will give serious consideration to these and other options as we move towards developing policy in this area. However, it is too early for me to point to specific actions we might take to improve health care for the uninsured.

Question

Many physicians are reluctant to serve Medicaid patients. What can we do to encourage physicians to provide services to this population?

Answer

We must have adequate provider participation in Medicaid to assure that beneficiaries have access to needed care. Medicaid reimbursement rates, high malpractice costs and other market forces may deter providers from participating in Medicaid. Generally, setting Medicaid reimbursement rates and regulating insurance are State responsibilities. However, we are working with physician groups and States to promote a greater understanding of the need for improved provider participation in Medicaid. In addition, the Department of Health and Human Services is providing funding for an evaluation of the AMA's proposed alternative to the tort system.

I am pleased to note that States have taken a number of steps to address this issue, particularly in the area of obstetrics and gynecology. For example:

- Twenty States reported plans to raise OB/GYN reimbursement rates in 1987-88; eleven States reported that rates for total obstetrical care were projected to increase 50%.
- A number of States are paying higher rates to providers that participate in special enhanced prenatal care programs for pregnant women.

- Many States are attempting to expand the use of certified nurse-midwives and nurse practitioners in maternity care and well-baby care programs.

- Some States are attempting to limit the effect of malpractice costs by establishing general liability funds.

There is no easy solution to this problem. However, we will be watching State initiatives closely and will use this information as we work with States to assure that there are a sufficient number of providers serving Medicaid beneficiaries.

Question

Do you favor allowing low-income individuals without insurance to "buy-in" to Medicaid?

Answer

One of my top priorities is to increase access to health care for the 37 million uninsured in this country. The uninsured are a varied group that includes low, middle and high income individuals, workers and the unemployed, and dependents of insured adults. Not all sub-groups of the uninsured have the same needs or economic resources; it is unlikely that any one approach will solve the problems of all the uninsured.

Many groups have provided the Department with reports containing recommendations for addressing the needs of uninsured. Allowing low-income individuals to "buy-in" to Medicaid is one of many possible approaches suggested in these thought-provoking reports. Over the coming months, we will be evaluating the recommendations in these reports as well as those proposed by the Congress as we move ahead with policy development in this area. However, it is too soon for me to specify what steps we will take to provide improved access to health care for the uninsured.

Adoption and Foster Care Information System

QUESTION:

Back in 1986, I sponsored legislation that required the Department of Health and Human Services to issue regulations establishing an information system on foster care and adoption programs. This requirement of law was obviously given low priority by the previous Administration, and as a result, those regulations, which were due last December, have apparently never gotten much beyond the planning state. In the meantime, those of us who have the responsibility to make national policy decisions affecting the most vulnerable children in this country are still without the information we need about these children (example, how old they are, what kinds of handicaps or special needs they have, why they were placed in foster care, and how long they have been there).

I raised this matter in our earlier visit. Have you had an opportunity to look into my question, and, if so, will you tell us whether we can expect the Department, under your leadership, to move those regulations to the front of its agenda?

ANSWER:

The Secretary's Report to Congress on Foster Care and Adoption

Data Collection System is still under review within the Administration. Regulations implementing a data collection system under current law are being drafted and will be put into clearance in the Office of Human Development Services in order to expedite the process.

The issue of a national data collection system for adoption and foster care is a complex one which raises many questions of individual and State's rights and appropriate areas of responsibilities. The Executive Branch has meticulously followed a process which ensures careful consideration of all relevant opinions and viewpoints regarding this important step in improving social services data collection and analysis. Although adhering faithfully to this process has often caused delays and setbacks in scheduling, it has been necessary to guarantee the integrity of both the report to Congress, and the system itself.

My colleagues and I will continue to work to resolve all outstanding issues in order to deliver the data collection report to Congress.

Senator Bentsen

Question:

Dr. Sullivan, last year, I wrote your predecessor a letter asking the Department to review the standards of determining disability eligibility for children under the Supplemental Security Income program. I understand that such a study is now under way. However, I believe that the Department has already developed, but not yet promulgated, revised standards for making childhood disability determinations in cases where mental impairments are at issue. Can you give us a commitment as to when you will promulgate these revised standards?

Answer:

The proposed revised standards have received Departmental approval and are in the final stages of intra-governmental clearance before publication in the Federal Register. We hope to publish a Notice of Proposed Rule Making in the near future.

Questions for Dr. Louis Sullivan

Submitted for the Record by Senator Chafee

Teen Pregnancy

Question: Enacted in the Family Support Act was a demonstration project to assist teenagers by providing counseling and activities to help prevent teenage pregnancy, suicide, and substance abuse. This program was not funded under the President's budget. Do you support funding for this and other programs such as this and will you be supportive of other preventive measures for our young people?

Response: The Family Support Act contains several requirements for States to focus their education, work and training efforts on the teenage population. As I have indicated, implementation of this major new initiative is one of my top priorities and I intend to strongly enforce all of these requirements. With regard to this specific evaluation component, it will be included in my review of all the demonstrations and evaluations contained in the Family Support Act. I must look very carefully at each of these projects and make a decision on whether to request funds in light of the flexible freeze requirements under President Bush's budget.

SENATOR CHAFEE

HOME DIALYSIS

Question:

Is it possible for those who are unable or unwilling to administer their own home dialysis treatment to pay out-of-pocket for the services of a technician to administer the treatment without jeopardizing Medicare coverage of the home dialysis equipment? What would be your position on this issue?

Answer:

Yes. Current policy permits a home dialysis patient to pay for the services of a trained dialysis technician. In this circumstance Medicare would continue to cover dialysis supplies and equipment.

Traditionally, Medicare-covered "home dialysis" has always meant and arrangement where the patient is trained for dialysis in an approved ESRD facility and subsequently dialyzes himself with the aid of a trained partner.

Medicare payment for home dialysis equipment would not be jeopardized if the patient and his partner, including someone employed by the patient, had been trained in dialysis procedures by a Medicare-approved ESRD facility.

In so-called "staff assisted" home dialysis, the patient is not trained for home dialysis because the treatment is preformed entirely by a staff member of a dialysis facility or supplier. In this situation, Medicare will not pay for the services of the staff member, but it will pay for necessary supplies and equipment.

The Department has proposed legislation with additional safeguards to assure the health and safety of home dialysis patients. Under this proposal, home dialysis patients would be required to have an agreement with a Medicare-approved ESRD facility to provide "back-up" services as necessary.

Senator Daschle

QUESTION:

Will you support legislation to implement a national nutrition monitoring program? What would you like to see in legislation creating a national nutrition monitoring program? Would it include a component to coordinate the two departments to speak with one voice and in compliance the "Dietary Guidelines for Americans"?

ANSWER:

It is my understanding that the Department has devoted considerable effort to strengthening coordination of nutrition monitoring activities and that and that recently a government-wide Interagency Committee on Nutrition Monitoring was established.

I would need to review the issue more thoroughly and, of course, consult with the Secretary of Agriculture before offering any comments on the need or desirability for legislation.

I support the provision of scientifically accurate, consistent dietary guidance to the public using the principles of the Dietary Guidelines for Americans. In fact, I understand that HHS has just joined with USDA to undertake a review of the Dietary Guidelines by a Federal Dietary Guidelines Advisory Committee.

With respect to providing quantitative recommendations, I believe that this should be approached cautiously. I would expect to continue working as well with the USDA on this.

QUESTION:

(a) What will you do to ensure that DHHS will not release misleading or conflicting dietary advice to the general public?
(b) Would you promote joint peer review of nutrition research projects and also of dietary guidance between the agencies of DHHS and USDA?

ANSWER:

There is currently a mechanism, through the Departmental Nutrition Policy Board to coordinate dietary guidance and ensure that we are producing internally consistent advice for the public. I strongly support peer review, and understand that a mechanism for interdepartmental review of dietary guidance information is currently in place through intradepartmental dietary guidance review committees.

Senator Dole

QUESTION:

What will you do to ensure that DHHS will not release misleading or conflicting dietary advice to the general public? Would you promote joint peer review of nutrition research projects and also of dietary guidance between the agencies of DHHS and USDA?

ANSWER:

There is currently a mechanism, through the Departmental Nutrition Policy Board to coordinate dietary guidance and ensure that we are producing internally consistent advice for the public.

I strongly support peer review, and understand that a mechanism for interdepartmental review of dietary guidance information is currently in place through interdepartmental dietary guidance review committees.

QUESTION:

What steps would you implement to ensure greater coordination between the two departments, Department of Health of Human Services (DHHS) and United States Department of Agriculture (USDA)? Do you support "The Dietary Guidelines for Americans" to be continued as a joint policy document made by DHHS and USDA? Do you envision risks in trying to make the guidelines a quantitative document?

ANSWER:

I understand that HHS-USDA coordination has continued to improve and I will certainly try to follow this trend. I support the provision of scientifically accurate, consistent dietary guidance to the public using the principles of the Dietary Guidelines for Americans. In fact, I understand that HHS has just joined with USDA to undertake a review of the Dietary Guidelines by a Federal Dietary Guidelines Advisory Committee.

With respect to providing quantitative recommendations, I believe that this should be approached cautiously. I would expect to continue working as well with the USDA on this.

Senator Dole

Question:

Dr. Sullivan, one of the recommendations of the HHS Disability Advisory Council (DAC) Report was an increase of the Substantial Gainful Activity (SGA) level -- the measure used to determine eligibility for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. The amount of earnings that constitute SGA is currently at $300 per month and should be adjusted to reflect the average wage growth since the SGA level was last increased in 1980. Congress and the Social Security Administration consistent with the DAC report recommendation support an increase to $490 per month. Keeping SGA low acts as a disincentive for SSI and SSDI beneficiaries and tightens eligibility standards for the programs more than Congress intended.

As Secretary of Health and Human Services (with the discretion to update the SGA), what are your plans to correct this inequity to ensure that individuals are not denied disability benefits due to the effects of inflation?

Answer:

I am aware that inflation has effected the value of disability benefits and intend to adopt several of the recommendations made by the Disability Advisory Council (DAC). In the near future, I will be working with the Office of Management and Budget to ensure that DAC proposals are implemented in accord with the program of the President.

Senator Heinz

Question:

Child care is an important concern for many working families and a topic of growing national interest. The President has voiced strong support for helping families through refundable tax credits. Yet, Title XX provides the single greatest direct subsidy of day care for low-income families. Will your Department examine the need to expand Title XX as part of a new child care policy?

Answer:

President Bush has proposed a new federal child care policy that has four key components: (1) a new and refundable tax credit of up to $1,000 for each child under age four in low-income working families; (2) the existing Dependent Care Tax Credit would also be made refundable and families could use whichever tax credit best suits their needs; (3) a $250 million increase for Head Start funding in 1990 to expand enrollments by up to 95,000 additional four year olds; and (4) examining barriers to liability insurance that may be restricting employers in their efforts to provide child care on or near worksites. There are no plans at this time to expand Title XX as part of a new child care policy.

Question:

Does the Department have any projects in the works to expand our knowledge of Title XX-funded day care in the States?

Answer:

Section 607 of P.L. 100-485, the Family Support Act of 1988, amended the State reporting requirements under Title XX, the Social Services Block Grant. The new reporting requirements, which will use uniform definitions currently being developed by the Department, will expand our knowledge of Title XX-funded day care in the States.

Response to Questions Submitted for the Record by
Senator Jesse Helms

Question 1:

What is an abortion?

Answer:

An abortion is the premature expulsion of a fetus from the womb, which may be either spontaneous or induced.

Question 2:

As a doctor, when do you believe life begins?

Answer:

I believe that life begins at conception.

Questions 3 and 4:

On December 18 you reportedly stated to the Atlanta Journal that you support a woman's right to an abortion. On December 21 you are quoted as saying, "...my private situation...is that there should be that right [to an abortion]." On January 23 Evans and Novak reported that you have told Senator Packwood you favor abortion. On January 24, the New York Times reported that you have told other legislators that you support legalized abortion.

How does your current position differ from all these accounts?

In the December 21 Atlanta Journal article you stated that you do not believe the Federal government should be involved in funding abortion "because it's such a divisive, emotional issue with such polarization on both sides."

How does your current position differ from the position you took on December 21?

Answer:

I am in full accord with President Bush's views on abortion. I oppose abortion except to save the life of the mother and in cases of rape and incest. I am in favor of a pro-life amendment to the Constitution and I am in favor of overturning Roe v. Wade.

Consistent with these views, I wholeheartedly support the Hyde Amendment. The Federal Government should not be funding abortions, except when the life of the mother is in danger.

Question 5:

Do you believe that tissues and organs should be removed from an aborted child while that child is still alive?

Answer:

No. Tissues and organs must not be removed from a living fetus, infant or child, nor an adult without his or her consent.

Questions 6 and 7:

Do you believe that tissues and organs should be removed from a dead aborted child?

On December 21 the Atlanta Journal reported that you favor fetal experimentation. How does your current position differ from that reported in the December 21 article?

Answer:

I have a strong conviction that no action should be taken that would encourage or promote abortion.

The Department of Health and Human Services has a longstanding commitment to the protection of all human subjects in research. In addition to the Department's broad regulations protecting research subjects, there are special regulations to guard against exploitation of vulnerable research subjects--especially pregnant women, fetuses and children.

Our regulations prevent the use of living fetuses in research unless there is a therapeutic benefit to the fetus or unless the research poses essentially no risk to the fetus (n.b. the test for this latter exception is that the research is conducted on fetuses in utero without reference to whether the fetus is to be carried to term or not). Congress has codified these strong protections into section 498 of the Public Health Service Act.

Question 8:

Should the lives of the handicapped be protected from the time of birth?

Answer:

Yes, the lives of the handicapped should be protected.

Question 9:

Do you oppose the actions of some doctors who deny lifesaving medical treatment or food and fluids to newly born handicapped infants?

Answer:

It follows from my previous answer that I would of course oppose actions that would deny lifesaving medical treatment or food and fluids to newly born handicapped infants. I believe medical care should always be provided when beneficial. In addition, nourishment should always be provided.

Question 10:

According to a press release of the Civil Rights Commission dated January 12, next month the Commission will release a report which recommends that the Executive Branch "resume investigation of allegations that children with disabilities are discriminatorily denied medical treatment based on handicap." Will you support the Commission's recommendations?

Answer:

I intend to explore with the Justice Department and HHS Department personnel what our authorities are in this area and the extent to which we are meeting our responsibilities. If there are deficiencies, I will make recommendations to correct them.

SENATOR MATSUNAGA

PAYMENT TO CERTIFIED REGISTERED NURSE ANESTHETISTS

Question:

On January 1, the Health Care Financing Administration began paying for nurse anesthesia services under a fee schedule. Proposed regulations were issued after the fact on January 26. The payments under the fee schedule are substantially below the cost of nurse anesthesia services according to both HCFA and the American Association of Nurse Anesthetists. Have you reviewed this matter and are you considering a higher payment level for the nurses? It is my understanding that a higher payment level could be achieved in a budget-neutral manner.

Answer:

The new policy was published as a Notice of Proposed Rulemaking on January 26, 1989, and the Department is soliciting public comment on it during the ensuing 60-day period. At the end of that period, all suggestions will be carefully evaluated. I believe it would not be appropriate for me to speculate on the outcome of that process.

Questions for Dr. Louis Sullivan

Submitted for the Record by Senator Moynihan

Institutional Capacity

Question: As Secretary, how will you create the institutional capacity necessary to successfully implement the Family Support Act?

Response: I have full confidence in the capabilities of the staff of the Department and in its ability to implement the Family Support Act successfully. For example, the Family Support Administration, which has primary responsibility for implementing most provisions of the Act, has extensive experience overseeing the implementation of child support enforcement and welfare work programs.

Following passage of the Child Support Enforcement Amendments of 1984, we worked closely with States in developing regulations and providing technical assistance so that these far-reaching changes to the child support program would be implemented on a timely basis. Also, since passage of the first AFDC work program component in 1981, staff currently in the Family Support Admnistration have worked closely with States in establishing Work Incentive Demonstration programs and the AFDC programs of Employment Search, Community Work Experience and Work Supplementation.

In areas where we have less institutional experience, such as education and training, we have been consulting extensively with other agencies in order to develop our own institutional capacity and we will continue to work very closely with these agencies throughout the implementation process.

Full Funding For the Family Support Act

Question: As Secretary, will you assure that the JOBS program, established as a capped entitlement program by the Family Support Act (Public Law 100-485), be funded, on an entitlement basis, in FY 90 and future years?

Response: I understand that, based on both Department and CBO estimates, the amount included for JOBS in President Reagan's FY 90 budget ($350 million) was considered sufficient to fund the JOBS and WIN programs for that year.

However, I am in the process of examining the Department's entire budget in light of the flexible freeze requirements under President Bush's budget. Following this review, I will make my recommendations to the President on the JOBS funding issue and other budget questions.

Questions for Dr. Louis Sullivan

Submitted for the Record by Senator Moynihan

Resources to Administer the New JOBS Program

Question: Dr. Sullivan, if the new welfare reform legislation is to succeed, I believe there must be strong Federal leadership to guide and assist the States in implementing the new JOBS program, and to evaluate their efforts. Will you please provide to the Committee a detailed analysis of the resources (including personnel) that you will have available in your Department in Fiscal Year 1990 to perform these functions? Please compare these resources to those available to the Department in Fiscal Year 1988 for similar purposes.

Response: Implementation of the Family Support Act is one of my top priorities. I have given lead responsibility for providing guidance to States on implementation to the Family Support Administration. The Family Support Administration has established a Task Group of approximately 20 of their best staff to develop the Notice of Proposed Rulemaking; coordinate with other key Federal agencies, such as the Departments of Labor, Interior and Education; and, respond to questions from the States, tribes and other groups interested in implementation of this major piece of legislation.

I will be monitoring all of these implementation activities very closely and assessing the need for additional resources in this area as part of my review of staffing levels throughout the Department.

In addition, I look forward to the naming of the newly-established Assistant Secretary for this agency, and anticipate that this individual will very carefully assess the staffing requirements within the Family Support Administration and report back to me.

Full Funding for the Family Support Act

Question: Will you support appropriations for the evaluations called for in the new Family Support Act?

Response: The Family Support Act creates a new education, work and training (JOBS) program for welfare recipients, provides both Medicaid and child care transition benefits for individuals who leave welfare as a result of employment, and specifically requires evaluation of each of these provisions. In addition, the statute requires that performance standards for the JOBS program be developed by FY 1994. In order to assess the effectiveness of this major new piece of legislation and develop these performance standards, I fully agree that a strong evaluation component is essential.

However, in addition to these evaluations, the Family Support Act calls for numerous other evaluations. I must look carefully at each of these provisions in light of evaluation funds currently available in the Department. If additional resources are required, then I will take this under consideration along with my review of the Department's entire budget in light of the flexible freeze requirements contained in President Bush's budget.

SENATOR
MOYNIHAN

Independent Living Program:

In the last Reagan Budget, there is a proposal to combine, into a new block grant, the Independent Living program, the Foster Care and Adoption Assistance administrative and training costs, and Child Welfare Services. According to the Reagan budget calculations, this new block grant would save over half a billion dollars.

The Bush Budget makes no discernible mention about this proposal.

Question: Is the Bush Administration still floating this proposal?

Answer: The legislative proposal was not explicitly mentioned in the budget submitted by President Bush. However, the President has made adoption a priority and the Department will be examining all activities that affect this process.

Question: If so, given that countless children are abused and even killed in foster care or in adoptive families, is this the right time to reduce federal funding for the administrative and training costs associated with Foster Care and Adoption Assistance?

Answer: The budget for President Bush does not reduce funding for adoption activities. In fact, Adoption Assistance was one of the priorities recognized in his budget.

Question: Will you assure full funding ($45 million) for the Independent Living program in FY 90?

Answer: Funding for the Independent Living program is assumed in the flexible freeze portion of President Bush's Budget, and the amount provided in 1990 is subject to negotiations with the Congress.

MEDICAL EDUCATION

Question:

How can we reconcile cuts in payments for medical education with the fact that these hospitals (teaching hospitals) get the sickest patients and in some cases, they provide the only health care available to the poor?

Answer:

Teaching hospitals are by no means the only hospitals that provide care to the poor. About half of all hospitals that receive a disproportionate share of low-income Medicare beneficiaries (and hence are paid a special adjustment) are teaching hospitals.

The additional payments made to teaching hospitals are intended to compensate such hospitals for the additional costs incurred by the presence of interns and residents and the sicker mix of patients.

Teaching hospitals have had the highest Medicare margins under PPS and, absent a reduction to indirect medical education payments, are expected to continue having the highest margins. At a time when margins are shrinking for all hospitals, it would be unfair to non-teaching hospitals to continue to over pay teaching hospitals. Medicare payments are intended to cover the costs of Medicare patients and should not be used to solve other problems in the health care system.

The Congressional Budget Office, the Office of the Inspector General, and the Prospective Payment Assessment Commission have all concluded that teaching hospitals are overpaid relative to other hospitals and have recommended that the indirect medical education adjustment be reduced.

HOSPITAL CAPITAL

Question:

How will Medicare address the capital concerns of States like New York?

Answer:

The capital reduction in the Administration's budget was proposed to constrain accelerated rates of growth in capital spending by an already overbuilt hospital industry. In FY 1987, occupancy rates declined in urban hospitals to about 60 percent, and about 40 percent in rural hospitals. Despite the decreasing occupancy rates, capital expenditures have grown at a faster rate than other inpatient hospital expenditures. Capital expenditures are about 10 to 12 percent of total Medicare payments for inpatient hospital services and without the constraints imposed by our budget proposal, they would likely continue to grow at an accelerated rate.

States like New York that have high hospital occupancy rates would probably benefit from a capital policy that reflects variations in occupancy. We will be examining alternative proposals, including an occupancy adjustment, in the coming months to determine if other approaches to constraining capital spending are possible.

Senator Moynihan

AREA WAGE INDEX

QUESTION:

Dr. Sullivan, in 1983, Congress created a new payment system for hospitals known as PPS (the Prospective Payment System). The system pays a rate that varies based on level of complexity, extent of teaching, extent to which is served as extremely high number of Medicaid and Medicare patients (disproportionate share), and the geographic variation in the labor cost of doing business. It was Congress's intent that the system be fine tuned over time as it evolved. To date, the system has not been fine tuned to sufficiently meet the needs of Congress and hospital providers.

What approach is your administration going to take with respect to fine tuning PPS with specific attention to the geographic area labor adjustment known as the AWI (area wage index)?

ANSWER:

I am aware that the area wage index is a very complex and controversial issue. I would need to explore the options for modification and the impact before deciding whether modifications are in order. In the short term, for the upcoming fiscal year, 1990, the Health Care Financing Administration plans to update the wage index to reflect the most recent, reliable wage information.

AREA WAGE INDEX

QUESTION:

The AWI, because it adjusts for 60% [sic; actually about 75] of the payment, is very important. The AWI uses wages and hours data classified into the MSAs (Metropolitan Statistical Areas) to calculate the AWI. The MSAs presently used were developed in 1980 and the wages and hours data is from 1982 and 1984. These data do not represent current patterns/trends and accordingly, the system is in need of some fine tuning in this area. I might point out that many of my constituents and those of many of my colleagues are adversely affected by the lack of updating of the area wage index and failure of the PPS system to reflect fine tuning adjustments.

Would you be willing to work with Congress on a way to update and improve the area wage index with specific emphasis on using the most current data available? Specifically, would you support a proposal to use wage data from the immediately preceding calendar year to calculate the wage index for use in the subsequent fiscal year, with annual updating thereafter? For example, use calendar 1988 data to calculate the 10/1/89 wage index?

ANSWER:

I would have to look into the feasibility. I believe the Department is required to promulgate revisions to the wage index at a certain time and I am not sure how this deadline would mesh with the Health Care Financing Administration's ability to collect the necessary data from hospitals.

Senator Moynihan

AREA WAGE INDEX

QUESTION:

Also, would you be willing to examine and alter, if necessary, the direction of present and planned HCFA research and policy development, so that it would reflect the notion of using the most current data and an examination of changing patterns that impact the wage index calculation and methodology?

ANSWER:

I am sure the Department wants to make the wage index as current as possible. However, I will be working with the Health Care Financing Administration to assure research and policy agendas accurately reflect the concerns you raise.

Senator Moynihan

Question: How does the Bush Administration propose to help states and hospitals pay for AIDS care?

Answer: The caring of AIDS patients and others infected with HIV will be a major concern to the Nation for some time to come. We must rely on our mixed private/public system of health care financing to provide the needed financial support. The Federal government is involved in paying for AIDS treatment, where the patients qualify. In 1990, we estimate that about $710 million in Medicaid and Medicare payments will finance care for AIDS patients, compared to an FY 1989 level of $520 million.

About 40 percent of all AIDS patients have their care paid for through the Medicaid program. The $670 million in Federal Medicaid payments, plus the approximately $670 million in State matching funds, pay for nearly 25 percent of total national AIDS medical care costs. The remainder of the AIDS patients are receiving services financed by the State and local governments, private insurance, and as either self-paying patients or, for those unable to pay, as "bad debt".

Nonetheless, certain barriers to care exist and several Departmental activities are well under way to seek solutions. The Department was charged by President Reagan to undertake an evaluation of our current system of health care financing to focus on the access to care of AIDS patients, both the uninsured and the underinsured, to increase the responsiveness of the system. The Health Care Financing Administration has begun this evaluation. HCFA and PHS are planning a series of regional conferences regarding the delivery and financing of health care services for HIV patients. In addition, PHS will continue to operate AIDS Service Demonstration Grants around the country. Further, HCFA is encouraging States, under the Medicaid home and community based waiver program, to provide more cost-effective care for persons who are at risk for becoming institutionalized, especially AIDS patients. Finally, Secretary Bowen issued an advisory letter to State governors and legislative leaders to encourage establishment of insurance risk pools for the medically uninsurable. Fifteen States have already created this type of program.

Question: Would the Bush Administration support waiving the 24-month Medicare waiting period for DI beneficiaries with AIDS?

Answer: This Department does not currently support waiving the 24-month Medicare waiting period for DI beneficiaries with AIDS. We are especially opposed to modifying benefits for a single disease or condition, such as AIDS or disabling HIV infection. The cost of shortening the waiting period for all Medicare disabled could be as high as $10 billion.

Question: How will the Bush Administration address the problem of discrimination against AIDS victims by insurance companies?

Answer: The regulation of life and health insurance is by law a state responsibility. Almost all states allow insurance companies to deny coverage to individual applicants who have substantial risk factors such as cancer or AIDS. Absent such practices, individual policies for life or health insurance would be subject to substantial "adverse risk selection" and become economically untenable.

In this regard, neither the Presidential Commission on the HIV Epidemic nor bills sponsored in the last Congress by Senator Kennedy and Congressman Waxman would have prohibited such insurance "discrimination."

For persons who are not eligible for group insurance policies and who have conditions which render them medically uninsurable as individuals, HHS strongly supports formation of risk pools.

Question:

What has happened to the study of the needs of children with AIDS in foster care, required by a Moynihan provision of the Omnibus Budget Reconciliation Act of 1987?

Answer:

The study called for in the Omnibus Budget Reconciliation Act of 1987 is currently in progress. At present, the Department is making site visits and collecting the required information about the numbers of HIV-infected children in hospitals requiring foster care placements, those already in foster care, and the problems associated with arranging for such placements. The report to Congress, which will be a full examination of the issues associated with HIV-infected children and foster care, will be submitted to Congress this summer.

Question:

What does the Bush Administration plan to do to help foster parents who agree to care for AIDS babies?

Answer:

As part of the Department's priority initiative to address Pediatric AIDS, the Administration, primarily through the Office of Human Development Services, (HDS) funded in FY 1988 almost $2.8 million in Pediatric AIDS projects utilizing funds from existing authorities. These projects address a range of issues, including services and support for foster parents who are care for AIDS babies.

These multi-year projects are designed and funded to develop models of local level coordination and care management to assure that foster and natural parents have knowledge of and access to appropriate services for the child with AIDS or HIV infection. Services needed by foster parents include training in care for the child, medical services, respite care, early childhood educational services, alternative care facilities, and support services.

We will be looking at the results of these projects and at other data to determine the focus of future activities.

Question:

What does the Bush Administration plan to do to help States place foster care children with AIDS?

Answer:

As a part of the Department's priority initiative to address Pediatric AIDS, the Administration, primarily through the Office of Human Development Services, (HDS) funded in FY 1988 almost $2.8 million in Pediatric AIDS projects utilizing funds from existing authorities. These projects address a range of issues, including recruitment and training of foster parents and development of support services to retain foster parents. Examples of projects include:

- HDS contracted with the Leake and Watts Children's Home in Yonkers, New York to develop and disseminate methods of recruiting, training, supporting, and retaining foster parents for HIV positive and AIDS children. Similar projects are also underway in New Jersey, California, and Illinois.

- In cooperation with the University of Washington, HDS funded the Child Welfare League and the States of New York and New Jersey to develop a videotape for the recruitment and training of foster parents, respite care providers, and Head Start personnel caring for HIV-infected and AIDS children. HDS plans to distribute this videotape widely.

We will be looking at the results of these projects and at other data to determine the focus of future activities.

Question:

What does the Bush Administration plan to do to help States and hospitals cope with the growing number of abandoned AIDS babies?

Answer:

We will continue to study this issue in order give guidance to States and hospitals in dealing with abandoned AIDS babies. We will be looking at the results of the projects we are funding and at other data to determine the focus of future activities.

NURSING SHORTAGE

QUESTION:

How will the Department of Health and Human Services address the nursing shortage and nursing salaries?

ANSWER:

In December 1988, a Commission on Nursing appointed by former Secretary Bowen made recommendations to address the nursing shortage. The Commission concluded that the shortage was primarily the result of increased demand for registered nurses, some of which was attributed to inappropriate utilization of nurses. The Commission also identified several other factors such as salary, wage compression, work environment, and lack of professional autonomy. Many of the recommendations addressing these issues are directed to the private sector.

As in the past, we re faced with a problem of competing priorities and limited resources. The Department will continue the efforts of the Commission, working with States, the health care industry, and other private sector organizations to enhance and increase their support for nurse training. I am concerned that the Department play a constructive role in helping to meet nursing personnel needs.

Senator Packwood

MEDICARE PROGRAM GROWTH

QUESTION:

What ideas will you put forth to curb the tremendous growth of Medicare parts A and B?

ANSWER:

While the growth in hospital expenditures has slowed, there remain subsidies in the hospital system which are clearly excessive. The President's FY 1990 budget calls for reductions in payments for capital-related expenses and for reform of medical education payments to hospitals. Teaching hospitals have experienced the highest average Medicare margins of any hospital group, and Medicare subsidies to these hospitals could be reduced to more accurately reflect the actual costs of these programs.

With respect to part B, Medicare spending for physicians' services, as you know, is growing rapidly. Research is underway to examine potential approaches to physician payment reform. As you know, one approach under review in the Department is to pay physicians according to a fee schedule based on a relative value scale.

Surely, one way to reduce costs is to restrain the inappropriate utilization of services. Not all medical services which are provided are necessary. Obviously, the recipient of these unnecessary procedures -- the patient -- would be better off as well if this kind of restraint were imposed.

I intend to explore all available options. In the interim, certain refinements to the present system -- such as reducing payments for overpriced procedures -- are called for to curtail spending.

RELATIVE VALUE SCALE

QUESTION:

What are the Department's views on the resource-based relative value scale? Why should Congress consider adopting the RVS if it does not control the volume of services provided?

ANSWER:

The study by Dr. Hsiao and his colleagues on the relative value scale has been the source of much discussion and analysis.

The analysis of this work is well underway, but as I am sure you will appreciate, the Department's position has not yet been determined on implementation of a relative value scale.

Question

For most working Americans and their dependents, health insurance is available through their employers. But a significiant number of our citizens -- some 37 million people, 88 percent of whom are workers or family members of workers -- report having no health insurance. What do you think can be done to address this problem?

Answer

I am aware that over the past several months, the Department of Health Human Services has received a number of thoughtful reports that address the problems of the uninsured; among them are

- The American Medical Association's report on Medicaid reform;
- the report of the National Leadership Commission on Health Care;
- the report of the National Commission to Prevent Infant Mortality;
- and two recent reports from the National Association of Children's Hospitals and Related Institutions.

I am also aware that the Congress is moving forward with its own analysis under the aegis of the U.S. Bipartisan Commission on Comprehensive Health Care.

The findings, observations, and ideas that emerge from these studies are being and will be helpful, and they will be considered as we move ahead in policy development in this field. But it is too soon for me to be able to define for you which course or courses of action we might propose for addressing the particular problems of sub-groups of the uninsured.

LONG TERM CARE

QUESTION:

The Medicare Catastrophic Coverage Act of 1988 calls for several studies on long-term care (LTC). Section 113 requires the Treasury Department to conduct a study of Federal tax policies to promote the private financing of LTC; Section 207 calls for Health and Human Services to conduct research on the financing and delivery of LTC services for Medicare beneficiaries -- for which $25 million was authorized. What role do you expect to play in examining and developing a LTC policy for this country? Do you believe the Federal government can afford annual expenditures of $20 billion to provide LTC coverage?

ANSWER:

I am keenly aware of the need to address the problem of financing long-term care services and I do except to play a role in developing a long-term care policy. The Department has nearly completed an analysis plan to carry out the research requested under Section 207. This research will be a coordinated effort by the Department agencies which have responsibility for long term care. I do not believe, however, that this should be just a Federal effort, but one which also involves State and local government and the private sector.

No, I do not believe the Federal government can afford to pay $20 billion a year for long-term care services. Currently, I believe the Federal share of Medicaid costs for nursing home care alone is $12 billion.

QUESTIONS FROM SENATOR DONALD RIEGLE, JR.

Q The Federal Government is in effect using the money in the Social Security trust funds to finance the day-to-day operations of government, giving the Social Security trust fund a series of IOUs which we will have to pay back sometime in the future. People are going to find themselves paying twice, paying their taxes now, and then paying back the IOUs in the future. Can we just do this indefinitely, or what would you propose we do to restore honest accounting to the Social Security system?

A The law requires that Social Security trust fund assets be invested in interest-bearing obligations of the United States or in obligations whose principal and interest are guaranteed by the United States. The liability of the Federal Government with respect to these obligations is no different from that on any marketable Treasury securities. The Federal Government must pay interest on the borrowed funds and must repay the principal when the obligations are redeemed or mature.

The solution to the problem you raise does not lie within the Social Security program. Rather, it is a national problem of reducing Federal deficits so that the Federal budget can be balanced without regard to the financial operations of the trust funds. In this way, the growth in trust fund reserves will represent real improvements in national savings, so that future generations will have greater wealth to draw upon when the time comes to redeem the holdings of the Social Security trust funds.

Q The Social Security Administration has been implementing a plan to reduce its staff size. Do you think we can continue to reduce staff levels at SSA without hurting quality of services?

A As of September 30, 1988, about 77% of the six-year plan to reduce SSA staff by approximately 17,000 FTEs from the FY 1984 level of 80,000 FTEs has been achieved. This is approximately 2,500 FTE's below the original plan projection for FY 1988. I believe that once the planned downsizing is completed in FY 1990, SSA staffing levels should be stable. I am confident that SSA can complete its plan to reduce staff while continuing to maintain its high quality of service to the public.

Q Do you support any proposals to make the Social Security Administration an independent agency, and what is your reasoning?

A I can see some obvious benefits from SSA being a part of HHS. For example, it fosters a close working relationship and coordination with other operating divisions in administering programs in which there are shared administrative responsibilities, such as Medicare. However, I expect to look carefully at the pro's and con's of any such proposal before I form an opinion.

Q As you know, the administrative definition of Substantial Gainful Activity (SGA), the measure used to determine eligibility for SSDI and SSI benefits, which is updated at the discretion of the Secretary of HHS, has not been revised for nine years. The failure to revise the SGA level over this period of time represents a serious departure from the previous administration of the program. Furthermore, the Disability Advisory Council appointed by the Secretary of HHS recommended in its report last March that:

"The amount of earnings that constitutes SGA should be adjusted to reflect the average wage growth since the SGA level

was last increased and should be indexed to average wage growth in future years."

Twenty-three Senators, including nine members of this committee, wrote Secretary Otis Bowen last September urging that this recommendation be adopted by HHS.

Do you plan to implement this recommendation, or to raise the SGA level a lesser amount? If so, when?

What further changes do you believe need to be made to increase work incentives for beneficiaries of SSDI?

A I understand that the Social Security Administration has prepared a regulation to increase the SGA level. It is being reviewed in the Department and recommendations will come to me soon. At that time, I expect to consider the issue of what level should be set for SGA, and forwarded to OMB for approval.

In response to your question on work incentive, I fully support President Bush's commitment to providing economic opportunities for persons with disabilities as stated in his February 9th 1989 speech to Congress. In speaking of persons with disabilities, the President stated:

"...you belong in the economic mainstream. We need your talents in America's workforce. Disabled Americans must become full partners in America's opportunity society."

One of my priorities will be to identify ways we can better assist the disabled to participate fully in our economy.

QUESTION FROM DONALD RIEGLE, JR.

Q Senator Bradley has introduced legislation with myself and others to require Medicaid coverage of all children under 18 from families with incomes under the federal poverty level. A Bush/Quayle campaign document stated that "George Bush supports proper health care through mandatory Medicaid coverage for all children with family incomes below 100% of the federal poverty level, working with those at highest risk as a first priority." Nevertheless, President Bush's budget contains no such proposals for children over age 1.

Do you share President Bush's commitment to this Medicaid expansion? Do you endorse the Bradley/Riegle approach, or what are your plans for implementing this commitment by President Bush?

A President Bush has sought in his budget to improve the health care needs of the low-income by first focussing on the most vulnerable of the high-risk group: pregnant women and their infants. I share that commitment.

Senator Symms

Question:

Do you think the Medicare reimbursement system works effectively? Are you in favor of any type of reform?

Answer:

I have been advised that the hospital prospective payment system has been successful in curbing the escalating growth in Medicare hospital payments from a rate of about 18 percent per enrollee in 1982 to about 2 percent in 1987.

One thing we need to look at now is how to restrain the growth in spending on outpatient services.

I prefer to withhold my judgment on any needed reforms until I've had an opportunity to review all the options.

Question:

What kind of emphasis do you intend to give the issue of rural health - where does it fall on your list of priorities?

Answer:

Rural health will be a priority for me, as Secretary, as it has been in the past.

Morehouse University's School of Medicine always had a strong emphasis on primary care and community practice. The undergraduates have preceptored, rotational assignments in rural and urban community practices, and the graduates serve in many rural communities throughout the nation.

The Area Health Education Center grant Morehouse received from the Department enabled the school to provide additional educational experience in rural communities for medical and nursing students as well as students in pharmacy and the allied health professions.

As we look to the nation as a whole, I am aware that 200 rural hospitals have closed their doors during this decade. I am aware of the chronic shortages of physicians and nurses and other health professionals in rural areas. The rise in rural poverty in recent years also has made it increasingly difficult for rural patients to pay for care. These are problems that clearly will require the attention of the Secretary.

I intend to make rural health a priority. I expect to work closely with the Congress, the States, local communities, and the private sector to develop approaches to solve rural health problems. I hope we can make real progress in this area.

Senator Symms

Question:

As Secretary of the Department of Health and Human Services, you will have the authority to remedy certain problems -- Pocatello and Chubbock in Idaho are cities separated b a street. Pocatello has a population of 47,000 and Chubbock has 5,000. This qualifies as a metropolitan statistical area, yet the hospitals there receive the rural reimbursement by Medicare. Will you use your authority to correct this situation?

Answer:

I understand that the law requires the Department to use the definition of metropolitan statistical area developed by the Office of Management and Budget. I would need to look into why the hospitals you mention do not meet those criteria, the Secretary's authority to make an exception to the legal requirements, and, of course whether such an exception is advisable.

NOMINATION OF DR. LOUIS SULLIVAN

Opening Remarks
by
Senator Steve Symms

Mr. Chairman and Members of the Commitee, I thank you for the opportunity to speak at this hearing.

I would like to say first, that I support the President in his decision to nominate Dr. Sullivan as Secretary of the Department of Health and Human Services. I am sure that Dr. Sullivan will do his best to represent President Bush while he holds this appointment. I would also hope that he will do his best to represent the concerns of Congress as well.

While I realize that the Department of Health and Human Services deals with a great many issues, I believe there are some that must take priority at this time. Near the top of the list is the issue of rural health. I am sure that every Senator here has heard from his constituency about the severe problems in the rural health care profession. In my State of Idaho, rural hospitals and rural referral centers receive approximately 70% of all admissions. We cannot let these facilities close their doors.

We need to restore equity in health care. By this I mean that hospitals should not be punished because of their location. Rural status should make hospitals all the more important as they are likely to be the only facility within miles. Those people that live in rural areas need health care just as everyone else. Yet our rural hospitals are closing all over the country. Doctors are leaving these areas to practice elsewhere.

I know that Dr. Sullivan is aware of the problem, however I want to emphasize the importance of rural health, not just to me and my State of Idaho, but to all of us.

I would also like to comment, for the record, on the pro-life issue that has received so much attention. I believe the court erred in its ruling on Roe vs. Wade, which legalized abortion, and that decision should be reversed. While I am aware of the controversy over Dr. Sullivan's position, a meeting with him in my office last week led me to believe that he shares the President's view on this issue.

Mr. Chairman, I have some questions for Dr. Sullivan that I would like to submit for the record. I also have questions to submit on behalf of Senator Helms.

And one more thing--why is HHS still holding onto those monkeys from Silver Spring?

COMMUNICATIONS

aascu

American Association of State Colleges and Universities
One Dupont Circle/Suite 700•Washington, DC 20036-1192•202/293-7070•Cable: AASCU-Washington, DC

February 8, 1989

The Honorable Lloyd M. Bentsen
U. S. Senate
Washington, DC 20510

Dear Senator Bentsen:

I am writing you on behalf of the American Association of State Colleges and Universities (AASCU) to support Dr. Louis Sullivan for the position of Secretary, Health and Human Services. Dr. Sullivan has an impeccable record of achievement in education; his credentials are well suited to the task of assuming the leadership of this key federal agency. Dr. Sullivan is a friend of education; he clearly understands and strongly promotes the substantial role education plays in addressing our nation's health issues.

Dr. Sullivan is extremely supportive of the Historically Black College initiative developed under Executive Order 12320. He understands the critical role education has played in offering educational opportunity to our nations' underclass citizens. Dr. Sullivan has demonstrated an unyielding support for strengthening medical research capability not only for Morehouse Medical College, but for other institutions of higher education in our country. His compassion for people and his skill in managing tasks and people will serve him well in the new administration. I have no doubt that Dr. Sullivan will leave his post in this administration with an impressive record of accomplishment especially in public policy issues of concern to the well being of this nation's populace.
If I can be of any assistance in supporting Dr. Sullivan for the position of Secretary, Health and Human Services, please do not hesitate to call upon me for that assistance.

With best personal regards.

Cordially,

Allan W. Ostar
President

The
American
College of
Obstetricians and
Gynecologists

February 14, 1989

The Honorable Lloyd Bentsen
SH-703 Hart Building
Washington, DC 20510

Dear Senator Bentsen:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization which represents more than 28,000 physicians specializing in delivery of health care to women, I would like to endorse the nomination of Louis W. Sullivan, MD, for Secretary of the Department of Health and Human Services (HHS) and urge his prompt confirmation.

As a physician, Dr. Sullivan understands the health care system and the impact that regulations issued at the federal level have on the health care received by this nation's citizens. Such an understanding improves the quality of government regulation.

Dr. Sullivan has extensive experience in two areas of great importance for the next several years — medical education and meeting the health care needs of underserved populations. He has been involved in educating physicians for over 20 years, culminating in expanding the Morehouse School of Medicine to a 4-year institution. With all the concerns about federal deficit, it should be noted that Morehouse has never had an operating deficit. Dr. Sullivan has thoughout his illustrious career demonstrated a commitment to assuring access to health care for the nation's underserved. This issue is at the forefront of everyone's health agenda and Dr. Sullivan can make valuable contributions to the critical debate on this issue.

Dr. Sullivan has a wide variety of experiences that would make him an excellent administrator of HHS. Again, ACOG urges his prompt confirmation so progress toward addressing our critical health care needs can begin immediately.

Sincerely,

Warren H. Pearse, MD
Executive Director

KB:sdm

409 12th Street, SW, Washington, DC 20024-2188 (202)638-5577

American
Dental
Association

1111 14th Street, N.W.
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ADA

February 7, 1989

The Honorable Lloyd Bentsen, Chairman
Senate Finance Committee
703 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Bentsen:

I am writing to express the endorsement of the American Dental Association for the confirmation of Dr. Louis W. Sullivan as Secretary of the Department of Health and Human Services.

Dr. Sullivan is a respected leader in the health community with a nationally recognized record of accomplishment. His background and unique talents are, we believe, well suited to the tasks that will confront the Department in the coming years.

The dental profession is looking forward to the opportunity of working with Dr. Sullivan and the Department in mutual efforts to improve the oral health of our nation. We urge your support for his confirmation.

I respectfully request the inclusion of this letter within the formal hearing record.

Sincerely,

Arthur A. Dugoni, D.D.S., M.S.D.
President

AAD:cjp

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • Fax (312) 645-4184 • Telex 28-0248

January 27, 1989

The Honorable Lloyd Bentsen
Chairman
Committee on Finance
United States Senate
205 Dirksen Senate Office Building
Washington, DC 20510

Re: Confirmation of Louis W. Sullivan, MD, as Secretary of the Department of Health and Human Services

Dear Senator Bentsen:

It is with great pleasure that the American Medical Association endorses the nomination of Louis W. Sullivan, MD, for the position of Secretary of the Department of Health and Human Services (HHS). Beyond a doubt, Dr. Sullivan is superbly qualified to assume this important position and we urge his prompt confirmation.

Dr. Sullivan is uniquely qualified to be the next Secretary of HHS. In addition to his compassionate nature and ability to view issues in human terms, he will bring to the position extensive experience that will be a tremendous asset in guiding the diverse and extensive operations of HHS.

For over twenty years, Dr. Sullivan has been on the front line of educating generations of physicians in medical schools starting at Harvard University, moving on to a distinguished career at Boston University School of Medicine and to his present position with the Morehouse School of Medicine. During these years, Dr. Sullivan also has been published extensively in scientific journals, served on editorial boards, and has been a valued advisor to entities within HHS, such as the National Institutes of Health and the Food and Drug Administration.

His work in leading Morehouse from a 2-year medical school to a full 4-year institution demonstrates a grasp of administration that is vital for being the chief administrator of the department responsible for the largest segment of the federal government's spending.

Dr. Sullivan also will bring to the position a unique history of caring. As a physician, Dr. Sullivan knows what it means to provide vital services to individuals who need care in meeting their health care needs. The AMA believes that experience as a physician is particularly relevant to heading HHS, and Dr. Sullivan's unique experiences make him an ideal candidate for HHS Secretary.

In his career, Dr. Sullivan has worn the hats of educator, administrator, editor, author, consultant, advocate, and physician. His combined experience in all of these areas demonstrate his qualifications to head HHS.

We urge you to consider favorably the nomination of Louis W. Sullivan, M.D. for Secretary of the Department of Health and Human Services.

Sincerely,

James H. Sammons, MD

JHS/bdb

AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0460

February 10, 1989

The Honorable Lloyd Bentsen
Chairman
Senate Committee on Finance
205 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the Association of American Medical Colleges (AAMC), I am writing to convey support for the nomination of Louis W. Sullivan, M.D. as Secretary of the Department of Health and Human Services. The AAMC represents the nation's 127 accredited medical schools, 435 teaching hospitals, and 87 academic societies. Given his background and many achievements in medicine, Dr. Sullivan's nomination is a source of tremendous pride for the medical education community. He is immensely qualified to be the nation's next DHHS Secretary and we urge his timely confirmation.

Dr. Sullivan is acclaimed in the medical education community for his lifelong commitment to medicine and the advancement of human health and for a selfless dedication to the poor and disadvantaged in American society. After graduating from the Boston University School of Medicine, serving in residencies at New York Hospital--Cornell Medical Center and Massachusetts General Hospital, and taking a research fellowship in hematology at Boston City Hospital and Harvard Medical School, Dr. Sullivan began a distinguished career in academic medicine. His early teaching and clinical research work includes posts at Harvard Medical School, New Jersey College of Medicine, and Boston University Medical Center and School of Medicine. His research activities involved studies of diseases of the blood, mainly anemias, and his research findings were important and have been widely published in science journals. During his tenure at Boston University, he also directed the Boston Sickle Cell Center.

In the mid-1970's, Dr. Sullivan channeled his extraordinary drive, determination, and vision into the establishment of a medical school at Morehouse College. By 1981, the Morehouse School of Medicine became independent of the college and converted to M.D. degree-granting status. Morehouse now has a total enrollment of 134. To credit Dr. Sullivan with singlehandedly founding, building, and supporting the school is not an understatement of his role and contribution. His involvement in Morehouse, which trains a significant share of black physicians in this country, also reflects a fervent commitment to the health and well-being of minorities and the disadvantaged in our nation.

While excelling as a physician, scientist, educator, and medical school administrator, Dr. Sullivan has always also managed to contribute time and energy to the goals and purposes of many medical and scientific societies and to serve with distinction on a number of important advisory boards and committees, including several at NIH, FDA, and the Veterans Administration. Throughout his career, he has exemplified the ideals and qualities of a strong and compassionate leader.

The AAMC believes Dr. Sullivan is richly qualified to take on the many challenges that lie at the helm of the Department of Health and Human Services. We urge your Committee to consider his nomination favorably.

Sincerely,

Robert G. Petersdorf, M.D.

Association of Professors of Medicine
1101 Connecticut Avenue ▪ Suite 700 ▪ Washington, DC 20036 ▪ (202) 857-1158

February 1, 1989

Dear Chairman Bentsen:

On behalf of the Association of Professors of Medicine (APM), representing the chairmen of the departments of medicine at our nation's 127 medical schools, I am writing to wholeheartedly endorse the nomination of Louis Sullivan, M.D. for the position of Secretary of the Department of Health and Human Services. It is the APM's strong belief that Dr. Sullivan is eminently qualified for this most important position and we urge you and your committee to move with swift confirmation.

Dr. Sullivan's background and wealth of experience in all aspects of medicine -- research, patient care, and education -- give him superb qualifications to head our nation's major health care agency. After training at such prominent medical institutions as Boston University School of Medicine, New York Hospital-Cornell Medical Center, the Massachusetts General Hospital, and the Harvard Medical School, Dr. Sullivan began a distinguished career as a clinical investigator/educator at Boston University Medical Center. Since 1975 Dr. Sullivan has been associated with the Morehouse School of Medicine, as the first dean and director of the Medical Education Program at Morehouse College and as president of the School of Medicine since it became independent from Morehouse College in 1981.

Exemplary of Dr. Sullivan's qualifications as a medical administrator is his guidance of Morehouse from a two-year medical institution to a fully-accredited four-year medical school. Such talents are essential in shepherding the federal agency responsible for such critical (and large) programs as Medicare, Medicaid, AFDC, and our nation's pre-eminent research institution, the NIH.

I can comment on Dr. Sullivan's qualifications from a personal perspective, as he and I served as colleagues when he was at Boston University Medical Center. During my tenure as chief of medicine at Boston City Hospital (one of the major teaching hospitals affiliated with Boston University Medical School), Dr. Sullivan served as chief of hematology in my department. In this position, Dr. Sullivan developed an outstanding clinical, academic and research record. He also showed himself to be an outstanding teacher, able to impart both the scientific and societal aspects of medicine to medical residents and students. This latter trait was particularly important at Boston City, as it serves a large number of poor and indigent patients. In sum, during the years that Dr. Sullivan and I worked together, he showed exemplary dedication to both the science of medicine, to medical education and to the art of healing.

Dr. Sullivan has been outstanding in all his various positions throughout his career, and demonstrated skills and expertise that qualify him to lead the DHHS. The APM urges you to act favorably upon his nomination.

Sincerely yours,

Norman G. Levinsky, M.D.

Norman G. Levinsky, M.D.
President

American
Psychiatric
Association

February 22, 1989

The Honorable Lloyd Bentsen
Chairman
Committee on Finance
United States Senate
205 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Bentsen:

The American Psychiatric Association, a medical specialty society representing more than 35,000 psychiatrists nationwide, is pleased to endorse the nomination of Louis W. Sullivan, M.D., as Secretary of Health and Human Services (HHS). Dr. Sullivan is eminently qualified to assume this important position and we urge his prompt confirmation.

Dr. Sullivan's career has provided him with all the necessary stepping-stones to perform in an excellent manner in the position of Secretary of HHS. In his career roles as educator, administrator, editor, author, consultant, advocate, and physician, Dr. Sullivan has come in contact with all aspects of the Health and Human Services system and will be able to take this knowledge and apply it as head of HHS.

For more than two decades, Dr. Sullivan has been in the forefront of educating generations of physicians in many medical schools. He has published extensively in scientific journals, served on editorial panels and been a valued advisor to many components of the Department of HHS.

The APA believes that experience as a physician is particularly relevant to directing the Department of HHS. Dr. Sullivan brings the important knowledge of caring for patients and administrative skill in making Morehouse a four year medical school.

We highly support the prompt confirmation of Dr. Sullivan as head of the Department of HHS.

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director

MS/ess/arn

American Speech-Language-Hearing Association
10801 Rockville Pike • Rockville, Maryland 20852 • (301) 897-5700 (Voice or TTY)

Office of the
PRESIDENT

Gilbert R. Herer, Ph.D.
Children's Hospital National Medical Center
Children's Hearing and Speech Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 745-5600

February 15, 1989

The Honorable Lloyd Bentsen
Chairman
Committee on Finance
U.S. Senate
205-Dirksen Office Bldg.
Washington, D.C. 20510-6200

Dear Senator Bentsen:

The American Speech-Language-Hearing Association (ASHA), representing 58,000 speech-language pathologists and audiologists nationwide, urges you and your Committee to recommend confirmation of Dr. Louis Sullivan as Secretary of Health and Human Services.

Dr. Sullivan is a distinguished leader in his field and is highly qualified to be Secretary of this important Cabinet position. His concern for the quality and efficiency of health care services and desire to develop and maintain high quality health professionals will lead to a more responsive health and human services system in the United States.

We thank you for your attention given this request. We look forward to Dr. Sullivan's confirmation.

Sincerely,

Gilbert R. Herer, Ph.D.

cc: John H. Sununu
Chief of Staff
The White House Office

Medical Association of Georgia

938 PEACHTREE STREET, N. E.
ATLANTA, GEORGIA 30309

February 3, 1989

Dear Senator Bentsen:

It is with great pleasure that I tender this letter in support of the confirmation of Dr. Louis W. Sullivan for the position of Secretary of Health and Human Services.

Dr. Sullivan is a person who I have know personally since his arrival in the State of Georgia in 1975. He is a man of the very highest moral and ethical standards and has a broad educational background of excellent caliber.

His educational attainments are clear in that he has become a member of Alpha Omega Alpha Honor Medical Society. He is a member of Phi Beta Kappa. He has attained all of the proper credentials as a physician in his chosen areas of Internal Medicine and Hematology.

He has participated in the affairs of organized medicine at a state and national level. He has participated widely in educational matters outside of the realm of medicine as indicated by his membership on the Board of Directors of the Southern Center for International studies and the University of Georgia Center for Continuing Education. He is also on the Board of the Robert Wood Johnson Health Policy Fellowship Program and has worked with several committees at the National Institutes of Health. He has served as a member of the National Advisory Counsel for the Division of Research Resources, National Institutes of Health. He has participated extensively in civic activities and has been a notable contributor in the arena of medical research.

The most outstanding character of Dr. Sullivan is his open, honest, intelligent and fair approach to all that he meets. He is a person of great insight with the ability to synthesize excellent approached to difficult problems. I can think of no man who is better fit for the position as Secretary of Health and Human Services.

It is, therefore, with greatest sense of pride that as President of the Medical Association of Georgia, I send you this letter encouraging Dr. Sullivan's placement in this position of great trust and import. I am certain you will find him capable and worthy of this responsibility and honor.

Very sincerely,

Joseph P. Bailey, Jr.

Joseph P. Bailey, Jr., M.D.
President

National Democratic Policy Committee

P.O. Box 17729 • Washington, D.C. 20041-0729

Thank you, Mr. Chairman, for the opportunity to submit this statement on the nomination of Dr. Louis Sullivan to become Secretary of Health and Human Services.

While much of any controversy that revolves around Dr. Sullivan's nomination will undoubtedly concern his position on abortion, and the NDPC hopes that he does in fact oppose abortion except under limited special circumstances, the NDPC would like to address the broader issues of AIDS and the frightening state of medical care in the nation. We must restore the inviolability of the principle of the sanctity of human life. The NDPC does not expect a Secretary of HHS to restore values for human life by himself, or without a genuine economic recovery to pay for what we as a society must pay for, but anyone in that position must be qualified to help lead a restoration of values for the sanctity of human life. If this committee confirms Dr. Sullivan, the NDPC hopes it will confirm him with this mandate.

First, this statement touches briefly upon the AIDS crisis. Second, a series of recommendations to deal with AIDS and the health crisis more generally are outlined. And thirdly, a picture of how dangerous and degenerate the health situation in this country has become.

The AIDS Crisis

The epidemic of infection with the Human Immunodeficiency Virus represents the most serious threat to human existence which we face. Already millions of persons in the United States and tens of millions worldwide are infected with this virus which is only one of a group of such viruses spreading under the collapsing health and sanitary conditions in the United States and the rest of the world. Once considered an affliction of homosexuals and IV drug users, it is now disseminating in the general population and has become the leading cause of death among young adults in a number of urban areas.

While there has been a reluctance to look beyond 1991 in terms of projecting the number of persons sick and infected with HIV, we must face the fact that that time will be past by the the end of the current administration. The present approach of not utilizing standard public health measures such as testing and upgrading health care, while politically and fiscally popular, is not containing the spread of HIV infection. As a result, if something is not done soon, this situation will change from a disaster to a catastrophe by the end of this administration.

HIV appears almost fiendishly devised to exploit the weak points of current policy. Initially spreading in the degenerate rock-drug-sex perversion cultural milieu of the last twenty years, it has acquired a political constituency which opposes effective control measures. This has enabled it to establish a firm foothold for

expansion into the general population. It's ability to persist for years before causing overt disease, or even stimulating an antibody response from the body has enabled it to become widely disseminated before its presence was even suspected. This presents us with a situation requiring a decisive long range program, based on a reasoned assessment of the actual biological situation, and not on the pragmatic, "crisis management" currently prevailing in national and international health policy. When the presently infected millions begin dying off en masse, which is just starting to occur, it will be too late for crisis management or any other approach, for that matter.

The present scientific approach of molecular biology will not provide a vaccine or cure. Ironically it has provided an impressive arsenal of highly sensitive and specific tests for the detection of infection, which we are presently committed to not using in a program of expanded testing and contact tracing. Thus we are engaged in a war for survival with a dangerous and resourceful enemy, the HIV virus and its cousins, and have decided to renounce the only effective weapons we possess in order to peddle pornography and drug paraphernalia.

NDPC PROPOSALS

The NDPC proposals include:

1) Not less than $3 billion a year for an Apollo-style "crash program" of research to develop a cure for AIDS.

2) Universal mass-testing for the infection, combined with public health and out-patient medical services to all infected persons and their families.

3) A large-scale program of constructing hospital-bed capacity for handling the expected case-load of AIDS-infected persons requiring hospital care.

4) An immediate suspension of all cost-containment research and consultants, estimated to absorb an astounding 15%-25% of this country's total health care expenditures annually. This includes investigating exactly what purpose HCFA fulfills.

5) A complete national assessment and rebuilding of trauma center-emergency services, including the availability of equipped ambulance, paramedics and physicians, for both urban and rural regions.

6) A complete national assessment of the collapse of rural and urban hospitals. How many languishing community hospitals have been bought up by for-profit corporations, only to be dropped when the profits turn marginal? What communities are totally without hospitals or nursing homes?

7) A complete reinstatment of all monies needed to hospitals responsible for teaching physicians. Medicare's latest ploy not to count all participating physicians is embarrassing.

8) Immediate reinstatment of those federal programs to pay back young doctors medical education loans in exchange for serving rural and indigent areas. The program must be expanded to make pay to these physicians available on a par with that of urban physicians to assure these communites have experienced medical practicioners available. A progressive upgrading program must be planned for these areas that replaced "clinics" with full fledged facilities and hospitals where necessary.

9) The U.S. is held hostage by the international insurance cartel. To eliminate the totally unfounded need for massive increases in physician liability insurance premiums, insurance

companies operating in the U.S. must be forced to open their books to show exactly what profits are being extracted at the cost of our citizens' lives.

10) Immediate regulation of the whole area of health cost-management companies, HMOs and its variations. As one of the originators of Blue Cross and Blue Shield told an interviewer many years ago: "When you control the health care of a country, you control the country." It is about time the government, as protector and leader of its people, take charge of the disastrous direction the industry of saving lives is headed.

11) Adopt economic policies that have America reclaim its productive and technological superiority world-wide. In the medical arena that means an immediate overview of the most advanced technologies and experimental programs available to assist at all levels of handicapped and critically ill individuals. Major publicized educational programs that bring physicians, patients, hospitals and the general citizenry to the brink of our medical scientific frontier, must be initiated and the technology must be made available.

For instance, patients with Lou Gehrig's Disease or Amytrophic Lateral Sclerosis (ALS), a devastating neuromuscular disease that results in the progressive paralysis of all muscles, have been told of every way to accomodate an early death from physician assisted starvation, refusing a ventilator to lethal pills. Yet, most of these people have been deprived of a few basic tools to function, like computers that allow them to communicate with their gaze. Or although they may be totally paralysed and unable to speak, eat, or breathe on their own, there is an experimental project that allows patients to operate phones, lights, TV, windows and even speak through an ordinary personal computer which responds to the brain's visual signals and is programmed to respond to the patient's gaze.

THE HISTORIC TRANSFORMATION OF AMERICAN MEDICINE TODAY

Will HHS Work to Stop a Nazi Transformation of Our Doctors?

Before the Nazi regime could initiate the medical butchery that later so stunned the world, they had to affect a major transformation of the German medical profession. The traditional medical ethic that doctors should under no circumstances take a patient's life, was immediately attacked as "erroneous". For under the Nazi regime, euthanasia for the incurably sick and insane, was considered the most "merciful treatment" and "an obligation to the Volk." The new medical ethic meant doctors had to be more concerned with the health of the Volk than with the individual. They were "doctor(s) to the Volkskorper (the national body or people's body)." This demanded, according to Nazi medical professor Rudolf Ramm, "a change in the attitude of each and every doctor, and a spiritual and mental regeneration of the entire profession." This reorganization process was known as "Gleichschaltung" or a shifting of gears of German medical layers in either a voluntary or coersive unification with Nazi ideological requirements.

There is alarming evidence that we in America are today witnessing just such a 'shifting of gears' within our health care system. There need not be a direct analogy to the Nazi concept of "duty to the Volk"--but the transformation of American medicine today, nonetheless, holds a chilling historic similarity. What monetarists within and out of government have created over the last decade and half is a monstrous machine which, under the guise of cost-containment, systematically dismantles the

science, education, and practice of traditional medical care. To the degree our health care delivery system contributes to its fundamental purpose in NURTURING human life, it is especially targeted by recurrent waves of budget cuts, managed health care schemes, and mandatory "quality of life" protocols.

But the goal, of course, is not to save costs, even if the Health Care Finance Administration and William Roper employ an army of actuaries whose expertise is used not unlike that of the Nazis who hit upon the cost-efficiency of making soap out of the carcasses of work camp victims. By one estimate, an outrageous 15 to 25% of every dollar spent on health care annually goes to "researching" developing newer cost-containment schemes!

Perhaps America's health care system has not been ordained to sacrifice the sick for the health of the Volk--yet. But what is clear, is the signal emanating from Wall Street, the insurance cartels, and the ruling, if invisible, hand of the Eastern Establishment, all of whom are committed to the economic and industrial collapse of the country. To guarantee their monetarist grip, America's health care vision must conform. It cannot simply be shrunk or distorted--the vision must be destroyed, lest the nation continue to demand the science, hope, and manpower to overcome the numerous medical crises before us.

Right now, doctors are now trained to think primarily about the "financial ramifications and cost-benefit equations" of their treatment decisions; elderly patients are brutally manipulated into believing that saving them deprives the next generation of "dwindling" resources; indigent pregnant women, desperate for critical prenatal care, are set against the needs of heart and cancer patients; and AIDS victims are told to go die quietly in a hospice.

No, our sick and elderly are not yet dying for the Volk, but they are daily triaged for an economic regime that differs from Hitler's ravages only in degree. The new administration affords the country an opportunity to reverse the process that forces the sacredness of individual human life, the most fundamental precept of American society and government, to bow to that reigning economic policy. This testimony will identify why the destruction of America's health care system is now rapidly approaching the point of no return.

THE FALLACY OF COST-EFFECTIVE HEALTH CARE

The incessant screaming about the costs of health care set the stage for handing over the reigns of the nation's health care to a bunch of fiscal experts who have no compunction about sacrificing a few thousand lives and calling it 'a hard choice'. The fallacy of such alleged cost-containment or budget gutting behavior can be seen in the total collapse of the health care delivery infrastructure and its supporting industry today. And the patient, at the mercy of such cutthroat behavior, ends up dead. As one medical economist noted, "The ultimate economy in medicine is death." Here are two examples.

Last year, 14 Congressmen had to sue to get HCFA to stop killing people by illegally and repeatedly denying Medicare benefits to thousands of elderly patients for "part-time or intermittent" home health care. After home care benefits were drastically cut in the early 1980's, HCFA then launched further restrictions that were never published or debated. It refused to pay for home care for more than four days a week--no matter how little time each day that care took. So patients who needed care for one hour a day for five days a week were denied care while those who needed 27 hours of care over four days qualified for

it. When someone needed help for five different days, they were denied benefits for the fifth day and lost Medicare coverage for the other four days as well. Medicare continued to illegally deny the claims of patients who won their appeals again and again. One patient died after her fourth sucessful appeal. The Federal District judge in the case labeled the government's action as "reprehensible". We call it murderous. These are not bureacratic oversights.

Last October, HCFA tried the same underhanded conniving when it announced to home care providers that Medicare would cut reimbursement for in-home dialysis treatments by 48%. Neither the 20,000 patients depending on these serivces nor their providers were consulted, nor was there the mandatory comment period. Home health care companies based their reimbursement rate on exactly what Medicare itself proposed for the treatment five years ago! Essentially, Medicare tried 1) to intimidate home care providers to cut cost and make it financially impossible for them to operate 2) to eliminate the large majority of immobilized sick and elderly patients unable to travel for dialysis treatment and 3) to shift all costs to Medicaid of patients who must be lifted and carried by trained personnel in ambulance transport three times a week (easily $100 per round trip three times weekly). The intention here was not cutting costs but cutting out, much as Britain has, a whole segment of the population over a certain age or illness level which the government no longer intends to have treated. Again, this after a court injunction restrained HCFA's actions.

The same relentless preying on the disabled appears indemic at the Social Security Administration. SSA has a campaign to intimidate, punish and coerce the independent 700 judges who review appeals of those who have been denied Social Security benefits into reducing the benefits the judges award. Any judge who awarded benefits in 70% of his cases was targetted for review by SSA. Again, only a lawsuit (from the Association of Adminsitrative Law Judges) stopped SSA's actions.

Now, SSA wants its own staff attorneys to be appointed judges to decide these cases and thus, totally control the appeals process according to the budget restrictions SSA sets--not according to the very real needs of the disabled. It is no wonder then that the SSA would consider drastically restricting the ability of millions of elderly and disabled people to appeal the Government's denial of their Social Security, Medicare and welfare benefits. With the government losing 50% of the appeal cases in which the blind, disabled or aged were unfairly denied benefits, the new plan to limit evidence would have "saved" billions.

Who is fooling whom? Is the country "saving" anything or are we just dismantling our health care capability? When each HCFA or foundation or insurance company "study" is activated, another part of the patient population is targeted for triage.

FRAMEWORK FOR RATIONING IN PLACE

The framework for rationing medical care is already in place, the Perspective Payment System. Since its inception Medicare's PPS has so underpaid hospitals for treatment of elderly patients that it is frequently charged with causing patient dumping, premature discharge of elderly patients, destroying the financial stability of hospitals and fueling the nursing shortage. By the Government's own accounting last summer, the hospital market basket has increased by 28.3%, while Medicare payments have increased only 12.16%. Government costs restraints mean that 60% of all hosptials will lose money this year, for others, the profit margin is "zero". Because DRGs do not cover the complicated medical treatment of chronically ill or long term cancer patients, just a few of these cases can put

a smaller hospital on the brink of bankruptcy. Over the last two years, 160 of those community hospitals did just that and closed.

To stave off impending crisis the National Rural Hospital Association filed suit on behalf of some 2,700 rural hospitals against the federal government calling its Medicare payment system to rural hospitals "unconstitutional". HHS is using the 1946 Hill-Burton Act to further cut reimbursement to rural hospitals. Hill Burton's "community service" stipulation is construed by HHS to mean that rural hospitals cannot turn away patients, including Medicare patients, no matter how low the reimbursment. The hospital's ability to provide community service and free care is jeopardized and thus, their due process rights are violated. Urban hospitals receive an average of 39.6% more than rural hospitals in payments for each DRG. As a result, over 87 rural hospitals shut down in 1986, another 40 community hospitals closed in 1987 and some 600 more rural hospitals are expected to close by 1990.

The nation's network of emergency service, initiated through the Federal Emergency Medical Sevices Act of 1973, is also being dismantled. With the 1981 Omnibus Budget Reconciliation Act the federal goverenment shifted the burden for financing sick services back to the states and local governments. This left vast portions of our rural areas without even a working ambulance or rescue capability to get patients to hospitals 30 to 45 to 60 minutes away. The national network of regional trauma centers that can handle major disasters with special personnel and equipment and blood supplies, appears permanently stalled as well.

The damage from DRG under-reimbursement rates from Medicare, Medicaid, and private insurers is compounded as states run out of Medicaid funds. Whole swaths of some cities are without hospitals altogether. Texas, Florida, California, Illinois and a host of other states increasingly face emergency room closings or have emergency care available on intermittent or "standby status" only (closed to ambulances), according to bed availability.

With DRGs came the predictable reduced length of hospital stay and less bed utilization. Per diem costs for non-Medicare patients zoomed since fewer patients absorbed the same overall expenses. With less utilization, Medicare cost-cutters, totally aloof to the medical needs of an increasingly sicker indigent population and AIDS patients, demanded hospitals decertify more beds or face penalties. Beds were cut, but it is only a matter of time before cities in general will face the resultant crisis now seen in New York City.

HOSPITALS THAT ARE "WORSE THAN BEIRUT"

One physician, with the appropriate experience, has characterized N.Y.'s hospital conditions as "worse than Beirut". Patients with heart attacks and strokes now often wait 12 to 36 hours to get into intensive care units. On any given day there are 400 to 500 patients waiting for a bed. For weeks, acutely ill patients are kept and treated in emergency rooms. Receiving their medications and meals is totally contingent on whether staff from other parts of the hospital are available to administer it. Patients wait 7-8 weeks for elective operations, if there is a doctor available to do it. Otherwise, these full-paying patients seek out a different hospital. Now the state will install an expensive computer system to moniter the number of beds available throughout the system to shuffle emergency patients from hospital to hospital. Up until last year, the state was still calling for removing hosptial beds from service "to save money". Over the last decade, over 13,000

hospital beds were decertified. All of this crisis management is needed just for normal daily activity, but what happens if a calamity occurs?

Yet, HCFA's second in command, Glenn D. Hackbarth says, "We could do just fine with a fewer hospitals." Hackbarth states unequivically, "In the next 5 to 10 years, we can do with fewer hospital beds that we have today. We don't need as many hospitals as we have right now." HCFA, William Roper and Hackbarth are all looking at balance sheets--not lives ,and criminally ignore the increasing needs of our growing elderly population and the catastrophic devastation by the AIDS epidemic.

With DRGs, physicians are pressured to release patients before it is medically appropriate and to dangerously delay admitting elderly patients until they "are sick enough" to pass DRG criteria. They are threatened with sanctions from the Peer Review Organization (PROs) unless they change treatment patterns for what they consider "medically inappropriate" reasons. PROs directly contributed to the demise of rural hospitals. In one case an 83 year old woman fell on her head. Because no radiologist was available to check for possible skull fracture, the doctor kept her overnight for observation after he gave her 20 stiches. Medicare called that "medically unnecessary" and refuse to pay. Since the woman lived, it was easy for Medicare to say she should have been treated and sent home. Medicare's prefers that doctors gamble with life. Had the woman died at home, the doctor could have been sued and lost his insurance. And another small town would have lost another physician.

Certificate of need programs and other stringent economic rate controls used to slow the acquisition of advanced diagnostic equipment and technology has been cited a possible cause contributing to higher death rates among patients in heavily regulated hospitals than those with less government regulation. Yet, HCFA's William Roper says "continued restraint...is necessary and does not compromise beneficiaries' access to the quality of care they receive." But the fallacy of cost-effective medicine has been demonstrated repeatedly in the way it jeopardizes not only the lives of individual patients but also the viability of America's entire hospital system.

The present climate of anti-new medical technology is actually undercutting the country's capacity to spur new breakthroughs in medical-scientific fields. Investors are dissuaded from developing new life-saving technologies because it is unlikely that financially strapped hospitals will purchase or be reimbursed for using them. Yet, not only does the newer equipment pay for itself, it saves more lives than outmoded technology.

With DRGs came an oppresive demand for documentation. Hospital administrators saw a 100 percent cost increase from paperwork alone. They were forced to canabalize medical staff and critical diagnostic equipment for accountants, form processors, and sophisticated cost-calculating computers. Fewer lab technicians led to slower and less accurate testing.

Underpaid, overworked nurses are driven out of their field by the burden of regulatory documentation and expanded patient load. Medicare budget cuts meant hospitals laid off 125,000 licensed practical nurses and nurses aids since 1983. That forced medical facilities to have registered nurses perform non-nursing duties that take up 10 to 60% of a nurse's time. By 1986, 83 percent of U.S. hospitals reported a shortage of nurses. Now, 18% of the nation's hospitals turn away patients due to shortages. In some New England Veterans Administration hospitals, OVER HALF OF THE BEDS WERE TAKEN OUT OF SERVICE due

to lack of staff. Thus, as a direct result of "cost-effective" policies, the nursing crisis has become so acute that HHS had to established a totally new Commission on Nursing to study the frightening shortage of 600,000 nurses by the year 2000.

With sharp reductions in hospital nursing staff, patients who need assistance with eating do not get it. Instead, they starve. Some 60,000 patients die of starvation in U.S. hospitals every year. One-third of all U.S hospital patients are malnourished and a half million more face critical complications because of it. If a patient loses 30 percent of his ideal body weight in the hospital--as one-third of all patients do--the chance of their living through an operation is reduced to about 5 percent!

"SCIENCE" BASED ON RATIONING POSTIVE FEEDBACK CYCLE

Such complications are, no doubt, a contributing factor in the recent series of studies that "prove" it is not cost-effective, that is, it is not worth resuscitating elderly hospital patients. Here we see how cost-cutting and cost containment policies becomes a positive feedback cycle. The so-called "science" derived from researching a patient population whose care is based on cost-effective medicine, in lieu of traditional medical treatment, is FUNDAMENTALLY FLAWED. Its only merit, like the experiments performed on Nazi work camp victims, is that it affords a reflections of the reigning economic purpose and modality--triage.

Health maintenance organizations, market competition, and the managed health care racket are all statistically linked with higher death rates, yet, HCFA has targetted that fierce cost-cutting weapon called capitation for greater use in Medicare. A flat per patient fee is paid to cover all the patient's medical care, tests, hospital admissions, physician referrals or consultations for an alotted time period. The number and kinds of abuses in this system which flag patients as either profit making assets or financial risks, are myriad, as the increasing number of suits and courts cases indicates.

Right now, a young Michigan mother of two, is suing her Blue Cross HMO specifically for putting her primary physician at financial risk through its "capitated gatekeeper" program. For over two years, the woman complained of horrible pain and vaginal bleeding as her private physician-gatekeeper profited from the tests he did not order and the timely specialist referrals he refused to allow. The patient, already a victim of the much heralded competition, had cervical cancer that had riddled her body and resulted in a radical hysterctomy and other gruelling operations. No amount of safeguards can make an intrinsically dangerous system safe. Whether for-profit or not, when these systems lose money, they carve deeper for profits and they cut lives.

In mental health care, these plans are known to be so disasterous that scores of attorneys, therapists and psychiatrists from coast to coast are protesting any HMO and managed mental health care. HMOs offer the minimum mental health benefits required for federal qualifications. They must technically provide 20 therapist visits per year, and 30 days of hospitalization per year, but if the HMO feels the visits are not useful or the condition is chronic, they can cut those visits. "Minimal care" means instead of inpatient hospital care, families must watch a suicidal relative around the clock, taking all night walks to calm hysterical patients and then go to work in the morning. The cycle consists of repeated emergency treatments and release but no inpatient care.

One of Blue Cross/Blue Shield's new mental health plan uses Psychiatric Manage Care Units or PMCUs that require psychiatrists to obtain permission for inpatient or outpatient treatment. Psychiatrists now must spend valuable hours on the phone answering sensitive confidential questions about patients, trying to convince social workers who admit no knowledge of the disease, that treatment is needed. Case managers "monitor" the patient's treatment, then authorize or deny services.

In another project, launched to cut company employee mental health and substance abuse treatment costs by 20-30%, managed care administrators guaranteed the company a certain percentage of the "savings" by denying treatment. Instead of inpatient programs specifically designed for several weeks of treatment, education and medical monitoring--crisis management is pushed. Case managers, with no medical experience, demand more aggressive drug therapy "to promote rapid (patient) removal from the hospital." In both cases, both the patient and the physician are so frustrated and intimidated, it was utimately impossible to give or receive treament. The vulnerable patient, too intimidated to fight for his treatment, regresses. Thus, costs are "saved" but the patient is lost.

All of the above schemes or variations thereof make up the basic core of the majority of national health care proposals we see today. As Senator Ted Kennedy put it years ago, "The only way to get cost-containment is to pass the national health insurance bill." In 1977, Kennedy went to a group of "ethicists" at the New York-based Hastings Center to discuss "what we can't talk about publically", that is, denying health care to sick people under a system of national health insurance. Sadly, even if this country were serious about providing health care to those 37 to 40 million citizens with little or no health care coverage, we would be woefully unprepared to do so. The lack of hospital beds and trained medical personnel would make the task impossible without the kind of mobilization to reverse the present rationing policies we have identified.

Another area of impending disaster is the totally unregulated, unsupervised field of cost management companies who make millions upon millions by "taking a scaple to health costs" in employee health care plans. These overseers, hired by major internist Dr. Eric Cassell, are cognitively incapacitated and by no means can be considered to be operating of their own free will.

To get relatives to make the "right" decisions, Prudential Insurance through its Prudential Foundation launched a nation-wide initiative in 1985 called "Bioethics in the Community: A Program of Local Decision Making". The community "democratically" decides what patients are to be sacrificed in health care rationing and euthanasia using brainwashing ploys called "patients' rights". "Oregon Health Care Decisions" is one such project that received funds from Prudential, Blue Cross/Blue Shield, and the Robert Wood Johnson Foundation. They held over 300 rigged public forums to "educate" the community about their health care "choices." Working with the Health Systems Agency, a new "allocation for fairness" doctrine was drawn up "to reflect the values of the communities". Using "studies" and cost analysis of expenditures for seriously ill newborns, comatose and terminally ill patients, the community was manipulated into accepting a controlled argument that medical triage of these costly patients is the only "fair" solution.

For years bio-ethicists connived to produce right-to die court rulings and laws that favor patient starvation because they say feeding is an extraordinary medical treatment that DOES NOT CURE the underlying disease. In 1987, they joined

forces with the Congressional Office of Technology Assessment to launch another heinous government-sponsored assault on American medicine. The OTA project, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY, set up a series of non-treatment patient categories which can be expanded upon according to the degree of rationing the government is willing to risk within the population. The study aims to eliminate antibiotics, tube and intravenous feeding and hydration, cardiopulmonary resusitation, renal dialysis, and mechanical ventilation, as "inappropriate treatment" for some patients. "Researched" by the top euthanasia ethicists in the country, the point of this study is to totally revamp America's medical protocols so the treatment you receive is no longer governed by what can be medically done to save your life.

The OTA Advisors assert that a patient's treatment will not be based on diagnosis alone, but on what is considered "beneficial" for him. If the chronically ill patient is confused or fuzzy, extending his life by feeding him would not be beneficial. If a cancer patient develops pneumonia, treating him with antibiotics may not be beneficial. "TO IMPROVE COST-EFFECTIVENESS," the Advisors state that feeding be eliminated for patients with "no 'meaningful' existence" or for whom "it is futile or inappropriate."

Hospitals will treat only those patients with a statistically known probability of survival. These statistical guidelines are disseminated through all medical education and training of health care professional--no doubt to stop young professional from looking for ways to surpass the present limitations of medicine and save more patients. Their Malthusian bottom line is this: "The fact that a reliable life-saving treatment exists does not mean that a person who will die without it, has a right to receive it..."

The recommendations from that study were published in a later OTA report called INSTITUTIONAL PROTOCOLS FOR DECISIONS ABOUT LIFE-SUSTAINING TREATMENTS. It recommended mandatory protocols for hospitals and nursing homes that stringently follow the patient's "wishes" to die without resorting to this or that treatment. The whole thrust of the report is how to arrange the patient's premature death, according to the living wills and durable power of attorneys hospital social workers help them with.

As if that were not enough, the ethicists are now also swarming the special interest groups, like the American Association for Retired People or the Americans For Generational Equity. Again they are selling health care rationing variously as "a choice" through "patient's rights" or "a necessity" to save the Social Security fund for the next generation.

And, with a slight of hand, ethicists can now point to new panoply of medical "research" that "proves" it is not only unethical but a waste of our manpower and financial resources to try to save, by resuscitation or other costly interventions, all those with a statistically low chance of survival.

That is how health care rationing and triage was sold to America. That is why the whole fabric of medical science, research, education and care is now rent.

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THE
ROBERT WOOD
JOHNSON
FOUNDATION

March 17, 1989

The Honorable Lloyd Bentsen
United States Senate
703 Senate Hart Office Building
Washington, D.C. 20510-4301

Dear Senator Bentsen:

During the recent confirmation hearings for Dr. Lewis Sullivan, certain testimony citing alleged activities of this Foundation were entered into the record.

We were said to fund - by the millions - promotion of birth control and abortion among children, as well as fetal tissue research projects.

None of this is true.

We underwrite no biomedical research projects whatsoever. Among our more than 700 grants now active in the U.S., is a comprehensive health services initiative, entitled The School-Based Adolescent Health Care Program, which is specifically prohibited from using Robert Wood Johnson Foundation funds to purchase drugs, including contraceptive medications and devices. Nor do we permit counseling on or about abortion in the clinics we support.

We are regularly credited - erroneously - in the media as the major underwriter of similarly named clinics throughout the nation. In fact, we support only nineteen.

The wrongful testimony offered during Dr. Sullivan's hearing has become a matter of great concern to our grantees, our staff and our trustees. We hope this clarification will go toward correcting the record.

Sincerely,

Thomas Pryor Gore II
Vice President for Communications

TPG:dss
cc: Judie Brown, President, American Life League
Van McMurty, Majority Staff Director and Chief Counsel
Ed Mihalski, Minority Chief of Staff

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